

13380

CERTIFICATE OF DEATH

13312

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pines-on-the Severn Rd.		d. STREET ADDRESS Pines-on-the Severn Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last John L Anderton		4. DATE OF DEATH Month Day Year December 11 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1910
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.	
11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Anderton		14. MOTHER'S MAIDEN NAME Amada Lockett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Emily I. Anderton Address Wife		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/10, 1960 to 12/11, 1960 , that I last saw the deceased alive on 12/10, 1960 , and that death occurred at M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard N. Peeler M.D.		ADDRESS (Street, city or town, state) 121 CATHEDRAL ST DATE SIGNED 12/14/60	
PHYSICIAN'S NAME (Type) RICHARD N. PEELER		ANNAPOLIS, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DEC 19 '60 24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1954

File No.

Dec 21 1954

[Illegible]

[Illegible]

Dec 21 1954

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

13336
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13313

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ANNAPOLIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle FRANKLIN Last ARMIGER SR.		4. DATE OF DEATH Month December Day 28 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 30, 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 28 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER-BRICKLAYER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME JOHN W. ARMIGER		14. MOTHER'S MAIDEN NAME LAURA M. KING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 202-05-1048	
17. INFORMANT CHARLES E. ARMIGER		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420-1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9 mos (c) 9 mos		INTERVAL BETWEEN ONSET AND DEATH 9 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12-28-60			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 11		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 17, 54 to 12-28-60 , that (I) (we) last saw the deceased alive on 12-22-60 , and that death occurred at 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE A. T. Allen		22b. DATE SIGNED 12/29/60	
22c. PHYSICIAN'S NAME (Type) A. T. Allen		22d. ADDRESS 62 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-31-60	
23c. NAME OF CEMETERY OR CREMATORY ST. MARYS CEMT.		23d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

1931

RECEIVED

1931

[Faint, mostly illegible text, possibly a letter or document, with some words like "Dear Sir" and "Yours faithfully" visible.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

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FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13381 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> c. LENGTH OF STAY IN 1b <u>Few seconds</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route 8</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> d. STREET ADDRESS <u>5512 Willys Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anthony Vincent Bahor</u>		4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>19 60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/34</u>
9. AGE (In years last birthday) <u>26</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer's aide at Westinghouse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pittsburg, Penn.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Michael Bahor</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>167-26-6338</u>	
17. INFORMANT <u>Mrs. A.V. Bahor (wife)</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull, fracture of left femur</u> 812 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Was fixing tire of Route 8 when was hit by another vehicle.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:45</u> a.m. <u>12/13</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 8</u>		20f. (City or town) (County) (State) <u>Linthicum</u> <u>AA</u> <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave N. Raubert M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave N. Raubert M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 12/12/60 DATE SIGNED	
22a. BURLIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>Dec 17-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Kitchen Bay Brooklyn Md</u>	
23. FUNERAL DIRECTOR <u>Bernard G. Fink</u>		24a. REC'D BY REGISTRAR <u>Glen Burnie Md</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>DEC 16 '60</u>			

1981

1981 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH
TIME OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
13382 CERTIFICATE OF DEATH 13315									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 1 1/2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital					d. STREET ADDRESS 845 Pierce Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Annie Middle J. Last Barnes					4. DATE OF DEATH Month 12 Day 30 Year 60				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1890?		9. AGE (In years last birthday) 70? yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown			16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Brain Syndrome associated with hyper- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO tensive Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Generalized Arteriosclerosis									INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 11/13/60 to 12/30 , 19 60 , that (I) (we) last saw the deceased alive on 12/30 , 19 60 , and that death occurred at 12/30/1960 M, from the causes and on the date stated above.									
22a. SIGNATURE <i>L. Benedict</i>					22b. DATE SIGNED 12/30/1960				
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.					22d. ADDRESS Crownsville State Hospital, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5-1-61		23c. NAME OF CEMETERY OR CREMATORY University, Md.			23d. LOCATION (City, town, or county) (State) Cath, Md		
24. FUNERAL DIRECTOR'S SIGNATURE Reese mortuary					ADDRESS Anna, Md		25a. REC'D BY REGISTRAR DATE JAN 6 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kross</i>

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UNITED STATES OF AMERICA

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THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
JAN 11 1900
SIR:
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter mentioned therein.
The same has been referred to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
J. H. ...

Very respectfully,
Your obedient servant,
J. H. ...
The Secretary of the Army
Washington, D. C.

Very respectfully,
Your obedient servant,
J. H. ...
The Secretary of the Army
Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13337

CERTIFICATE OF DEATH

13316

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN lb 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis			
f. STREET ADDRESS 1 Rt-1, Box-29				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clara Middle BARNES Last BARNES				4. DATE OF DEATH Month December Day 15 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 26, 1890	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70		IF UNDER 24 HRS. Months 70 Days 70 Hours 70 Min. 70			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				Maryland			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 740			
17. INFORMANT Harrison Barnes				Address Rt. 1 Box 29 Annap. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia Pulmonary Edema 260 X DUE TO (b) Uncontrolled Diabetes, Gargano Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Uncontrolled Diabetes, Gargano							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Annapolis							
20f. (City or town) (County) (State)							
21. I certify that (I) (the deceased) attended the deceased from Dec. 11, 1960 to Dec. 15, 1960 , that (I) XXX last saw the deceased alive on Dec. 15, 1960 , and that death occurred at 6:10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE A. T. Allen M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 12/16/60							
22c. PHYSICIAN'S NAME (Type) A. T. ALLEN 22d. ADDRESS 62 Cathedral St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12-20-60 23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn 23d. LOCATION (City, town, or county) (State) Baltimore, Md.							
24. FUNERAL DIRECTOR'S SIGNATURE William Reese, 2 Anna. Md. ADDRESS 2 Anna. Md. 25a. REC'D BY REGISTRAR DEC 19 '60 25b. REGISTRAR'S SIGNATURE William S. Reese							

MEDICAL CERTIFICATION

1941

1941



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HEALTH—BALTIMORE, 18

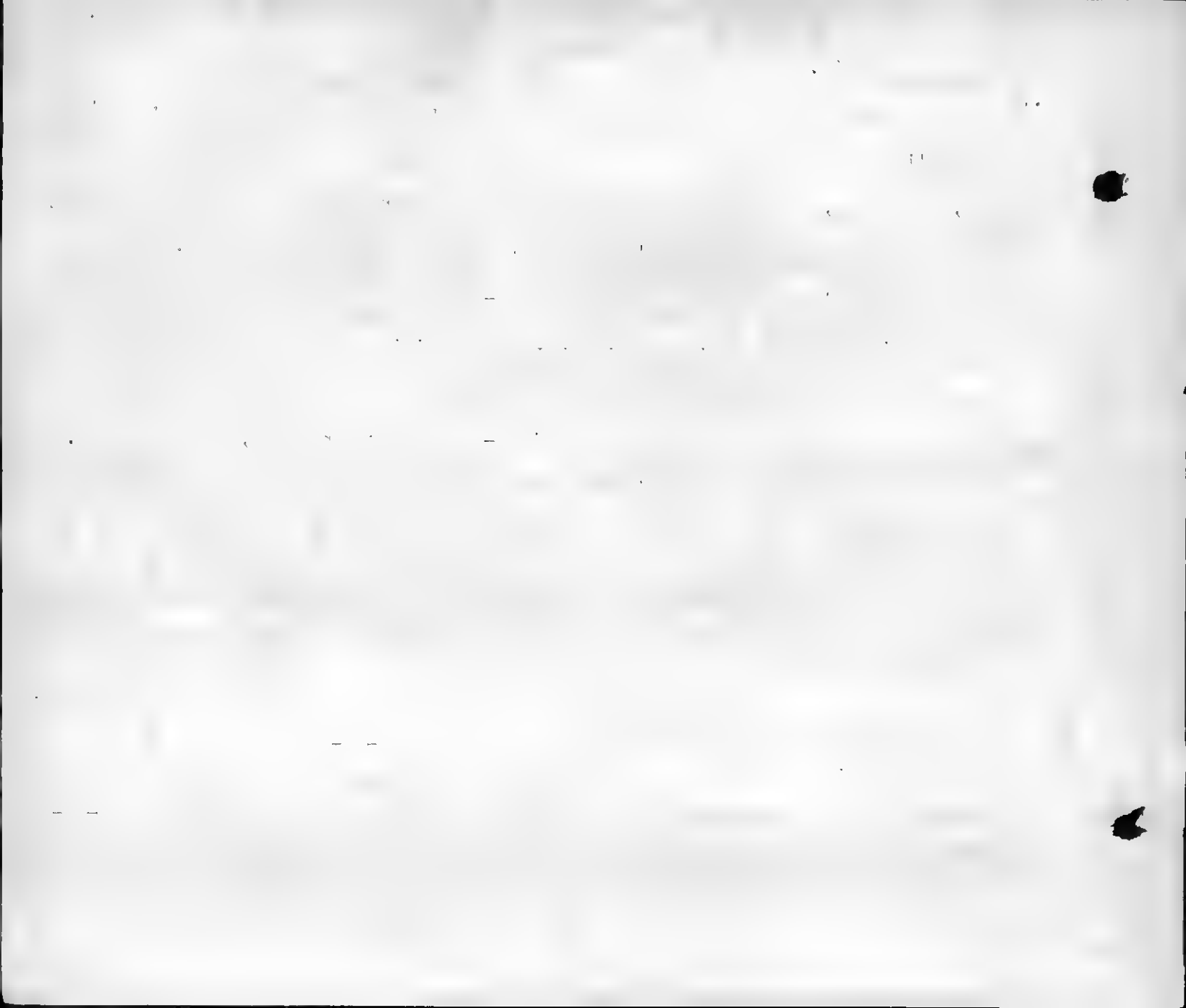
13353 CERTIFICATE OF DEATH

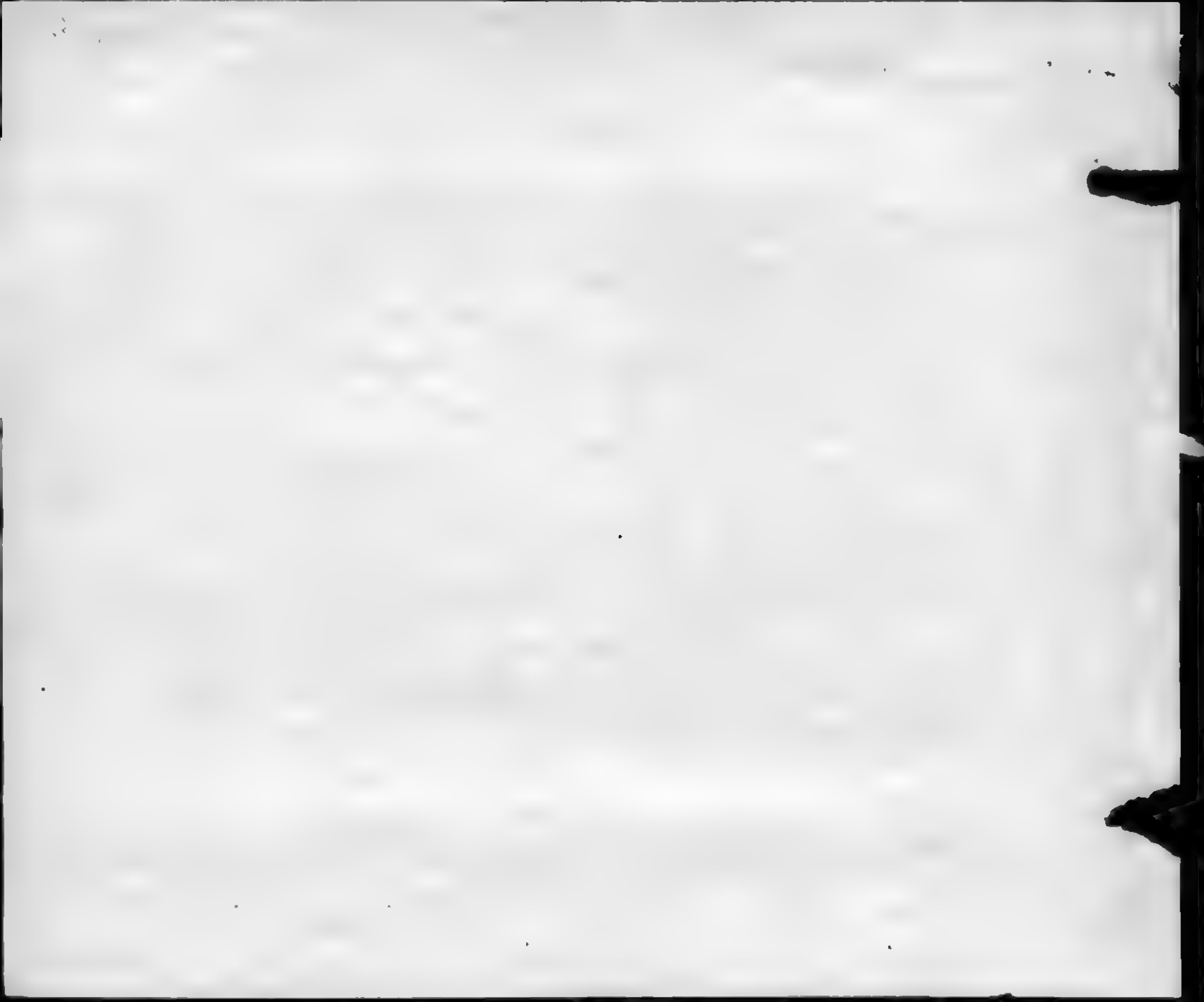
13317

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>MARYLAND</u> <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN lb <u>Herondale</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LSNH, ANNAPOLIS, MARYLAND</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Herondale</u> d. STREET ADDRESS <u>1801 Matravers Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>BILLINGS</u> Middle <u>Alfred</u> Last <u>Isadore</u> 4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1960</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-8-93</u> 9. AGE (In years lost birthday) <u>67</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN (Retired)</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>---</u> 11. BIRTHPLACE (State or foreign country) <u>Louisiana</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Abraham Issac BILLINGS</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Ida LANGLOIS</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>ww I and II</u> 16. SOCIAL SECURITY NO <u>---</u> 17. INFORMANT <u>Wife - 1801 Matravers Road, Herondale, Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>19</u> a. m. <u>19</u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>8-16-60</u> , 19 <u> </u> , to <u>12-25-60</u> , 19 <u> </u> , that I last saw the deceased alive on <u>12-25-60</u> , 19 <u> </u> , and that death occurred at <u>7:35A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>12-25-60</u> ACTUAL SIGNATURE <u>EC Keene</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>E. C. KEENE, LT MG USNR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Dec 28-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u> 22d. LOCATION (City, town, or county) <u>Barby Pa</u> (State) _____				23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph H. Frank</u> ADDRESS <u>Glen Burn Md</u> 24. REC'D BY REGISTRAR <u>DEC 29 '60</u> 24b. REGISTRAR'S SIGNATURE <u>E. W. S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

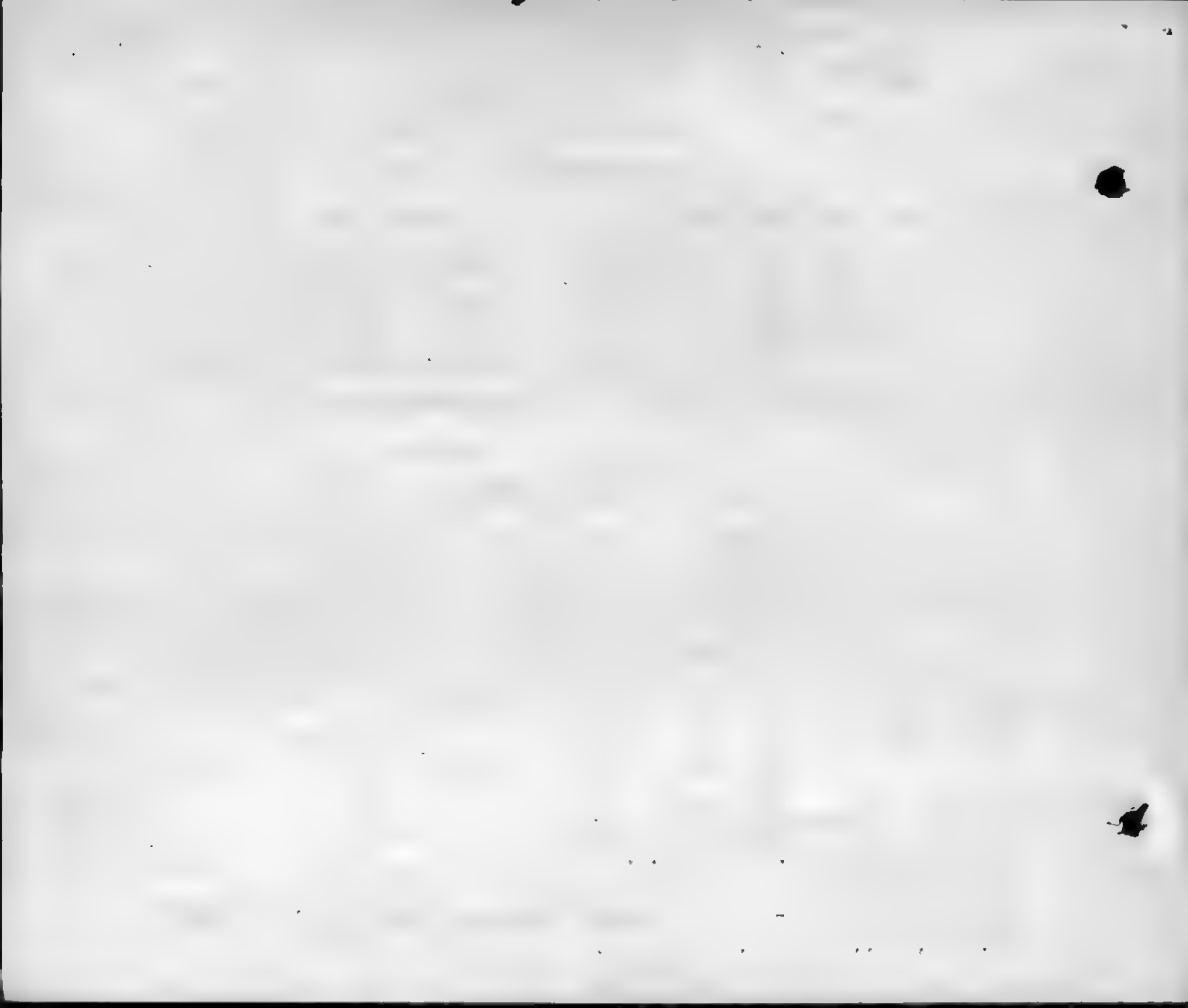
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13384

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13319

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Meade</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>	
c. LENGTH OF STAY IN 1b <u>Few seconds</u>		d. STREET ADDRESS <u>Route 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fort Meade Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GLENNA</u> <u>MARGARET</u> <u>BLAND</u>		4. DATE OF DEATH Month Day Year <u>December</u> <u>4</u> , <u>1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8/21/60</u>	
9. AGE (In years last birthday) <u>3</u> <u>13</u> yrs. Months Days		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Seattle, Washington</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elbert Bland</u>		14. MOTHER'S MAIDEN NAME <u>Lucile Bunting</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The parents</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u> 492X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/5/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>12-8-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Seattle, Washington</u>	
23. FUNERAL DIRECTOR <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>DEC 9 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>John S. Frank</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13338

CERTIFICATE OF DEATH

13320

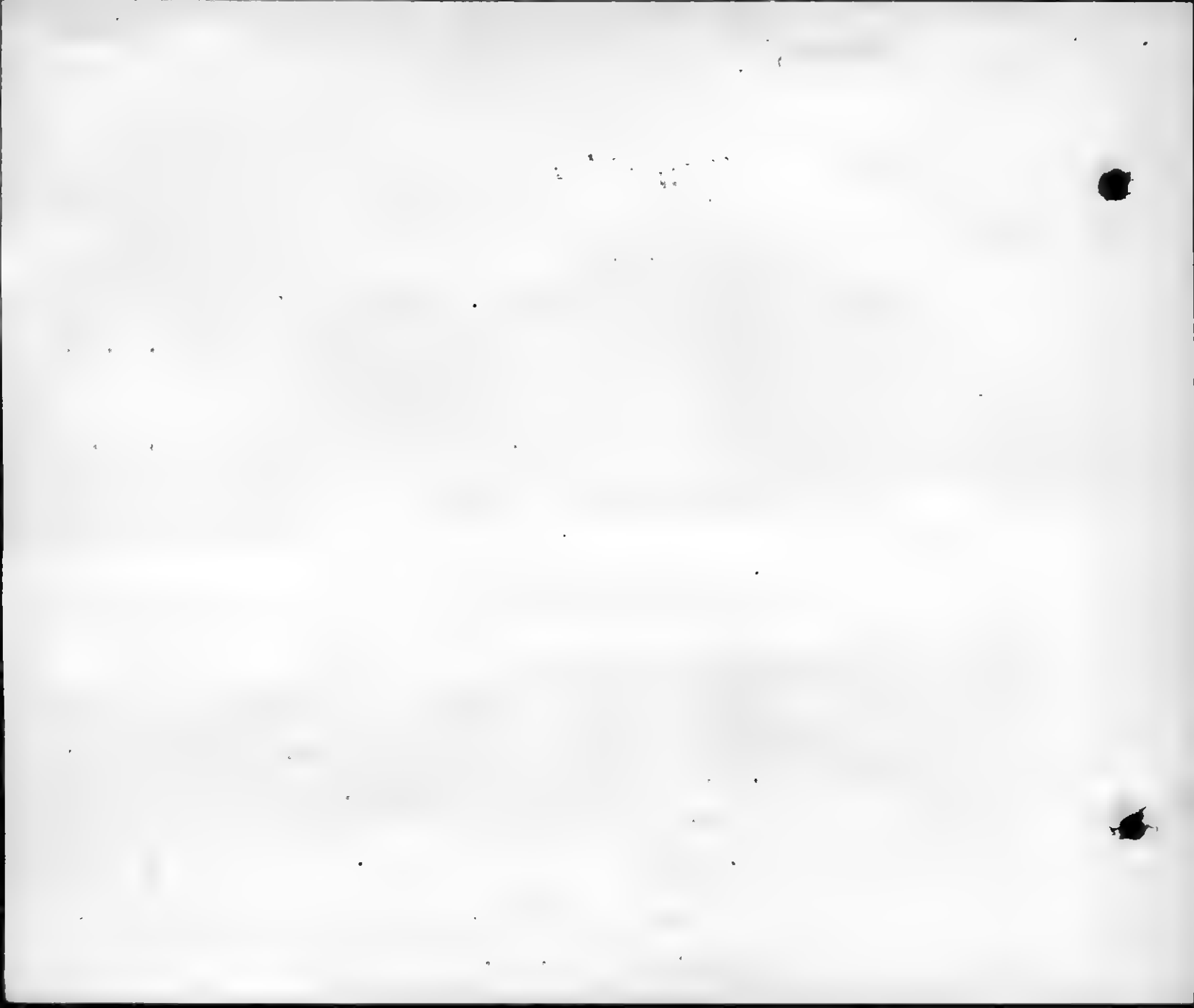
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1128 Tyler Ave</i>				d. STREET ADDRESS <i>1128 Tyler Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mary Frances Boettcher</i>				4. DATE OF DEATH Month Day Year <i>12-23 1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 16-1904</i>	9. AGE (In years last birthday) <i>56 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Sandy Hook N. J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>Griffith H. Thomasson</i>				14. MOTHER'S MAIDEN NAME <i>Sallie Lou King</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>J. Earle Boettcher</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>11 mos.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1960</i> , to <i>12-23 1960</i> , that I last saw the deceased alive on <i>12-23 1960</i> , and that death occurred at <i>1:52</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E. Linhardt</i>				M.D. <i>Charles H. King</i>		DATE SIGNED <i>12/23/60</i>	
PHYSICIAN'S NAME (Type) <i>E. Linhardt</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-26-1960</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cent</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>				ADDRESS <i>Annapolis Md</i>		24a. REG'D BY REGISTRAR DATE <i>DEC 26 60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
13339 MARYLAND STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH 13321									
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Lothian				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital					d. STREET ADDRESS /Brookwoods Road			• IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF (Type or print) Ellen First NORA Middle BRADY Last					4. DATE DEATH December 13 1960				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 14, 1883		9. AGE (in years last birthday) 77 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Tenant		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME ----- Hooper					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) N O		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Wallace McKenzie-Lothian, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial pneumonia</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Cerebral vascular accident</u> DUE TO (c) <u>Diphtheria mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month. Day Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from Aug. 1958, to Dec. 12, 1960, that (I) (we) last saw the deceased alive on Dec. 12, 1960, and that death occurred at 3:55 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Emily H. Wilson					M.D. ATTENDING PHYS. XX MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/13/60		
22c. PHYSICIAN'S NAME (Type) Dr. Emily H. Wilson					22d. ADDRESS Lothian, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/17/60		23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery			23d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Marlboro, Md.					25a. REC'D BY REGISTRAR DATE DEC 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



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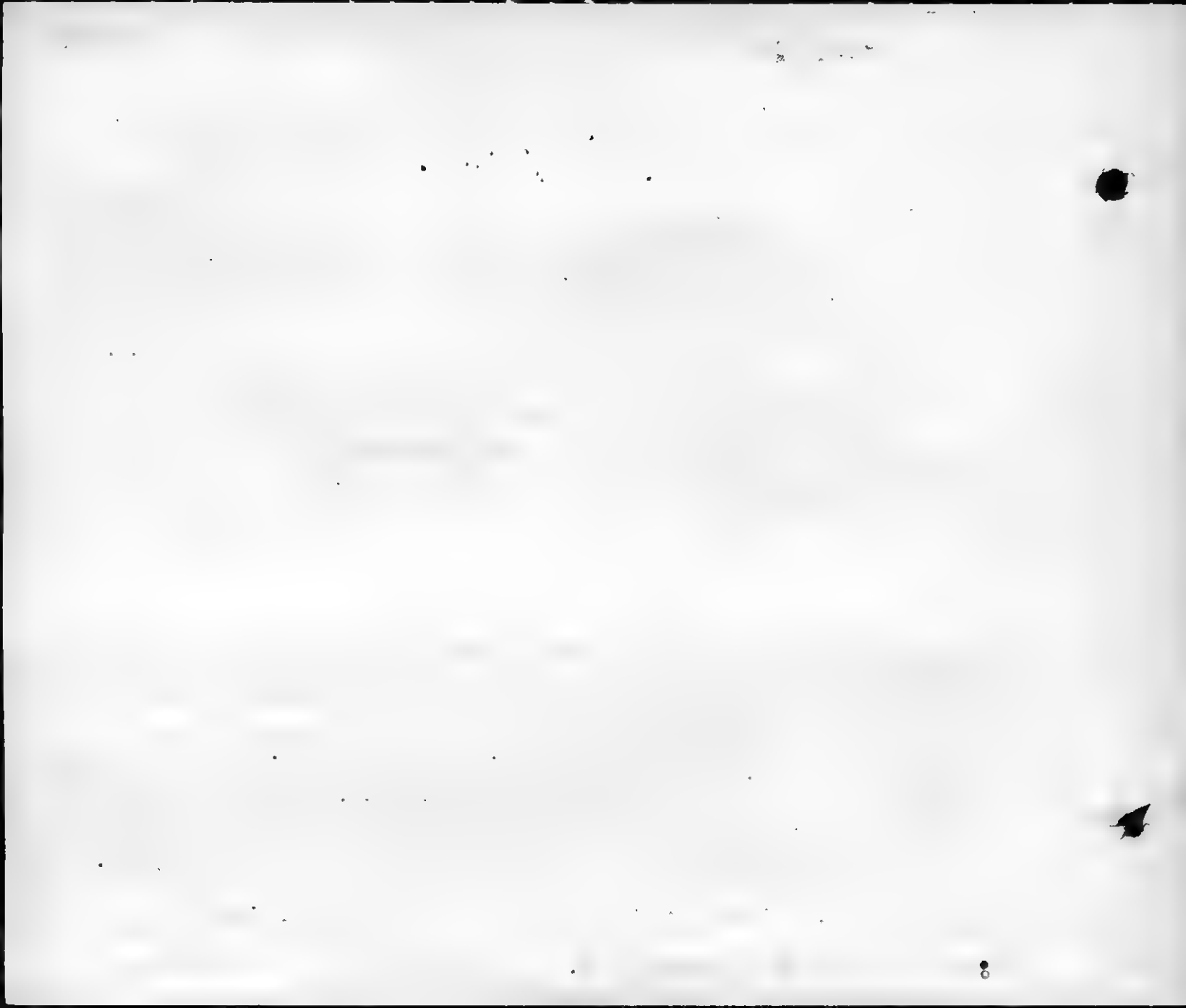
VR A15 (11-55M)

13340

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13322

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Harwood		
c. LENGTH OF STAY IN 1b 1 day			d. STREET ADDRESS 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Peggy Middle Irene Last BRADY			4. DATE OF DEATH Month December Day 20 Year 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 19, 1960		9. AGE (In years last birthday) yrs. 22 Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Basil BRADY		14. MOTHER'S MAIDEN NAME Dorothy Christine CLARKE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7711 DUE TO (b) Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Prematurity					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (the hospital) attended the deceased from Dec. 19, 19 60 to Dec. 20, 19 60 , that (I) (we) last saw the deceased alive on Dec. 20, 19 60 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Clayton Norton M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/22/60	
22c. PHYSICIAN'S NAME (Type) Clayton Norton		22d. ADDRESS Medical Building, Severna Park, Md.			
23a. BURIAL, CREMATATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 23, 1960		23c. NAME OF CEMETERY OR CREMATORY Mt Zion	
23d. LOCATION (City, town, or county) (State) Lothian, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Md.		25a. REC'D. BY REGISTRAR DEC 27 '60	
25b. REGISTRAR'S SIGNATURE Clayton S. Hanning					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

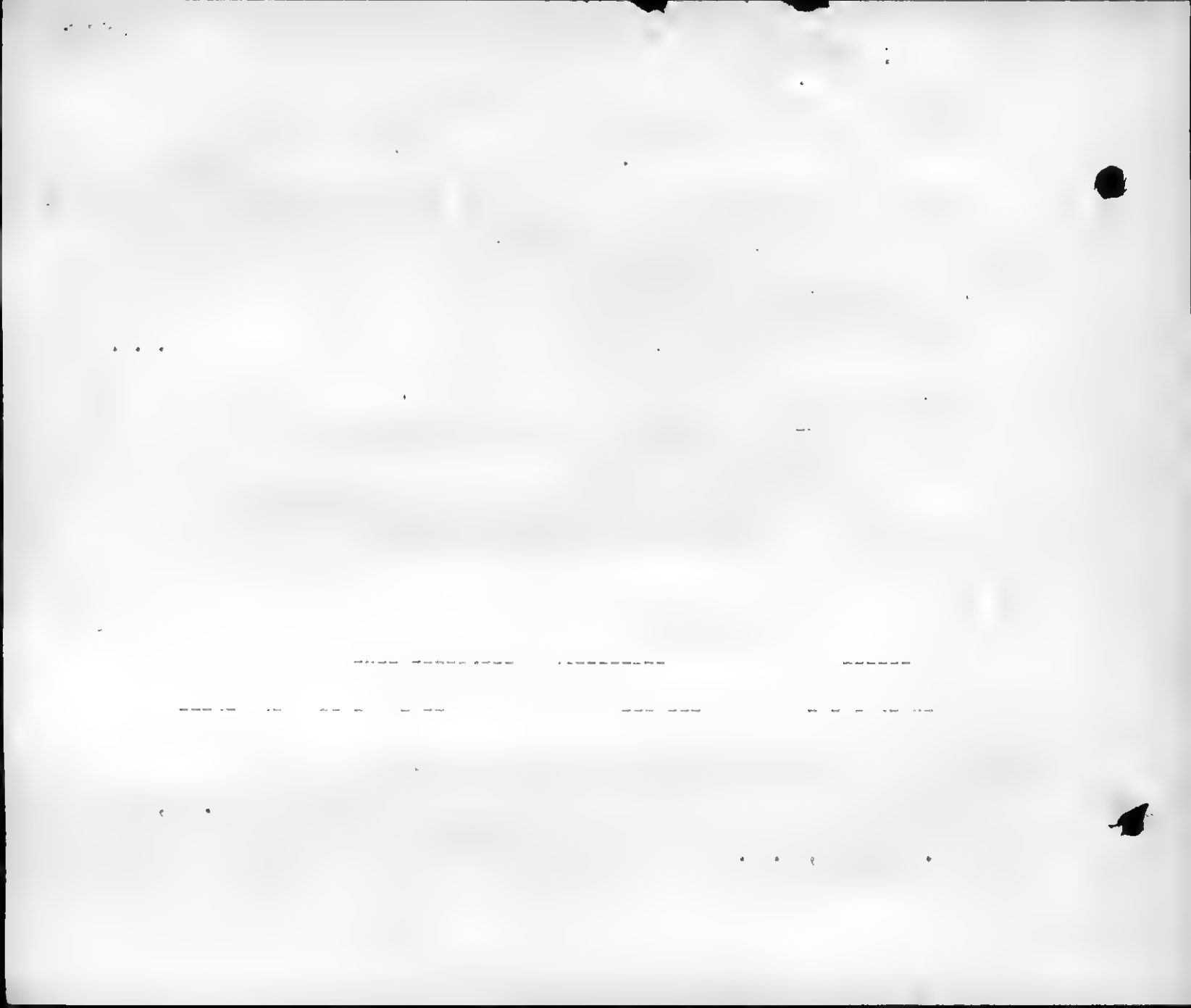
13385

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13323

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF TIME IN 1b 9 mos. 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 226 Schroeder Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thaddeus Middle Brice Last Brice				4. DATE OF DEATH Month 12 Day 28 Year 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/1888		9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Brice				14. MOTHER'S MAIDEN NAME Sallie ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Chronic Brain Syndrome associated with Cerebral and Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Paresis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTE TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour 9:25 p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) at work		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/6/1933 to 12/28 , 19 60 , that (I) (we) last saw the deceased alive on 12/28 , 19 60 , and that death occurred at 9:25 AM , from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict, M. D.				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Dec. 28, 1960	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL CREMATION REMOVAL (Specify) 12/28/60		23b. DATE THEREOF 12/28/60		23c. NAME OF CEMETERY OR CREMATORY mt Auburn		23d. LOCATION (City, town or county) (State) Baltimore Md	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kline				ADDRESS 1348		25a. REC'D BY REGISTRAR Jan 3 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION



1. PLACE OF DEATH a. COUNTY <i>aa</i>			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>202 Prince George St.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Jean</i> Middle <i>Andrews</i> Last <i>Champion</i>			4. DATE OF DEATH Month <i>12</i> - Day <i>18</i> Year <i>1960</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 22^d 1900</i>	9. AGE (in years last birthday) <i>60</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hostess</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>House</i>		11. BIRTHPLACE (State or foreign country) <i>San Francisco Cal</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S A</i>		13. FATHER'S NAME <i>Philip Andrews</i>			
14. MOTHER'S MAIDEN NAME <i>Clara Fuller</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>E. C. Champion</i> <i>939 Hillcrest Circle Oakland Cal.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyper-tension Cardiac Insufficiency</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <i>19</i> o. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>E. Linhart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>12.18.60</i>	
EXAMINER'S NAME (Type) <i>E. Linhart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Dec 23-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	22d. LOCATION (City, town, or county)	(State) <i>Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>			24a. REC'D BY REGISTRAR DATE <i>DEC 23 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Huns</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

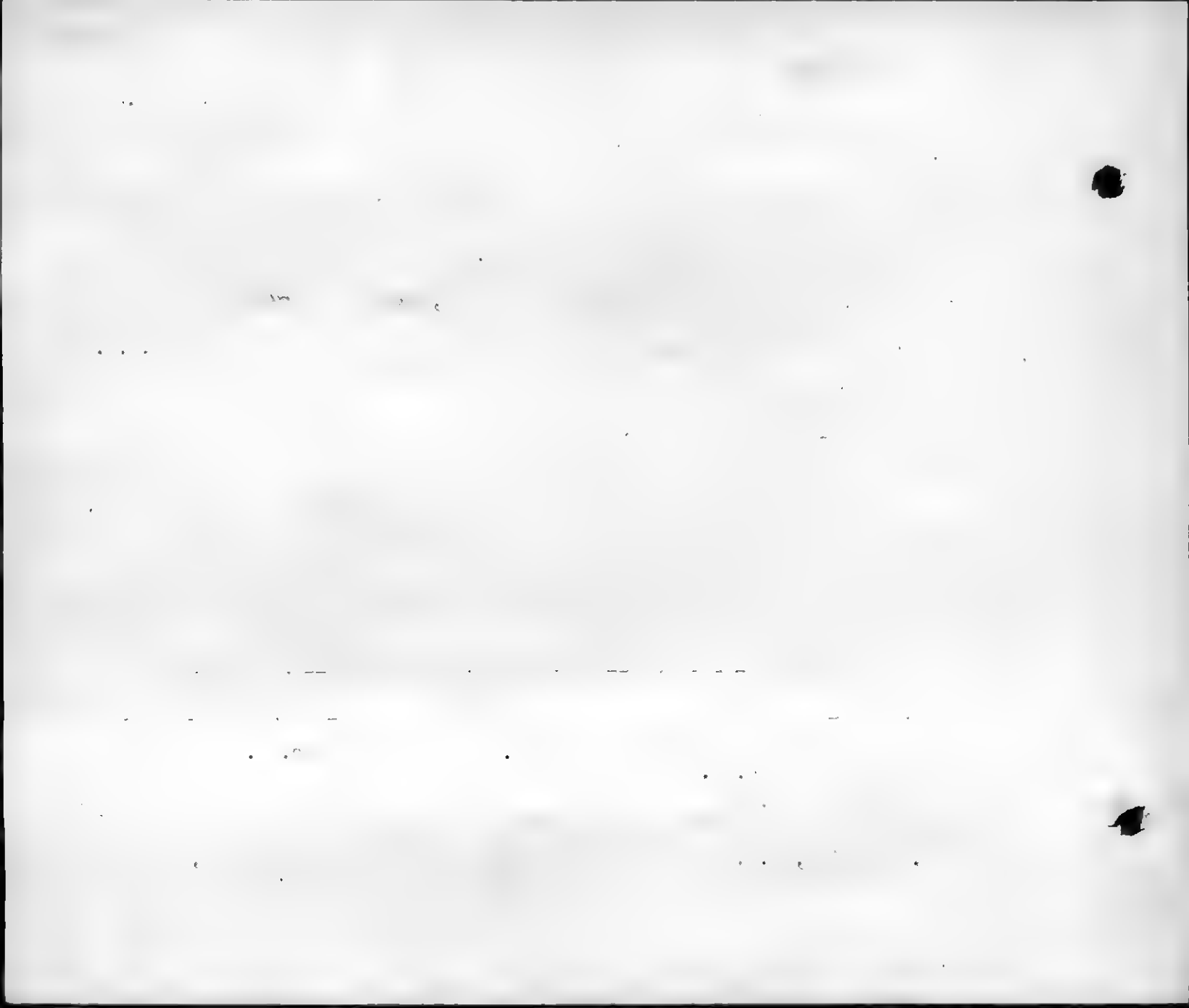
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13325

13386

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 15 yrs 10 mos 24 days							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1730 Division Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Harry Middle Chester Last Chester				4. DATE OF DEATH Month 12 Day 6 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1896	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 6 Hours 15 Min.		IF UNDER 24 HRS Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Tom Chester				14. MOTHER'S MAIDEN NAME Laura Grant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decompensatory Heart Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c) Arteriosclerotic Cardiovascular Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month 12 Day 19 Year 1960 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore, Md.				20g. (County) Baltimore		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1945 to Dec. 6, 1960 , that (I) (we) last saw the deceased alive on Dec. 6, 1960 , and that death occurred at 6 AM , from the causes and on the date stated above.							
22a. SIGNATURE <i>L. Benedict</i>				22b. DATE December 6, 1960			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-60		23c. NAME OF CEMETERY OR CREMATORY W.H. Gluck		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert K. Williams</i>				25a. REC'D BY REGISTRAR DEC 9 '60		25b. REGISTRAR'S SIGNATURE <i>C. J. Williams</i>	

BPP



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

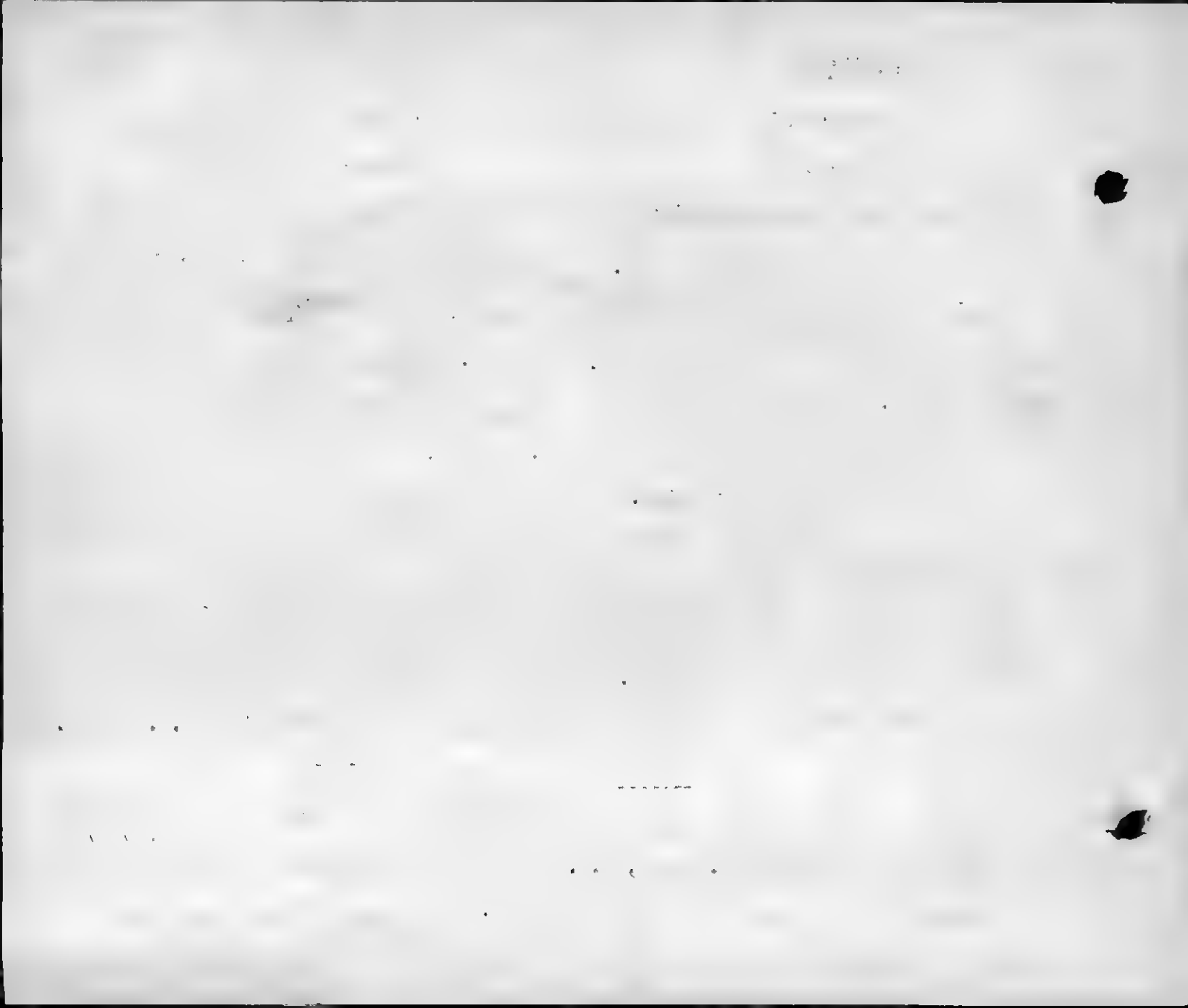
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13342

13326

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY C c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2802 Delaware Avenue	
3. NAME OF DECEASED (Type or print) HOWARD M. COCKERELL		4. DATE OF DEATH December 12 19 60	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1909	
9. AGE (in years last birthday) 51		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer		10b. KIND OF BUSINESS OR INDUSTRY Stewart & Co.	
11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John E. Cockerill		14. MOTHER'S MAIDEN NAME Alice Pritchard	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. Mr. Edgar P. Cockerill- 2802 Delaware Avenue	
17. INFORMANT Mr. Edgar P. Cockerill- 2802 Delaware Avenue		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning. DUE TO (b) 851X DUE TO (c) 851X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat sunk.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
22a. TIME OF INJURY 12/12 19 60		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay		22d. (City or town) Off Annapolis (County) A.A. (State) Md.	
23. ACTUAL SIGNATURE Charles S. Petty		24. DATE SIGNED 12/13/60	
23. EXAMINER'S NAME (Type) Charles S. Petty, M.D.		24. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
25a. BURIAL, CREMATION, REMOVAL (Specify) Burial		25b. DATE THEREOF 12/16/60	
25c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		25d. LOCATION (City, town, or country) Elkridge, Maryland	
26. REC'D BY REGISTRAR DEC 15 '60		26. REGISTRAR'S SIGNATURE John J. Pickner & Sons Inc. Balto. 17, Md.	

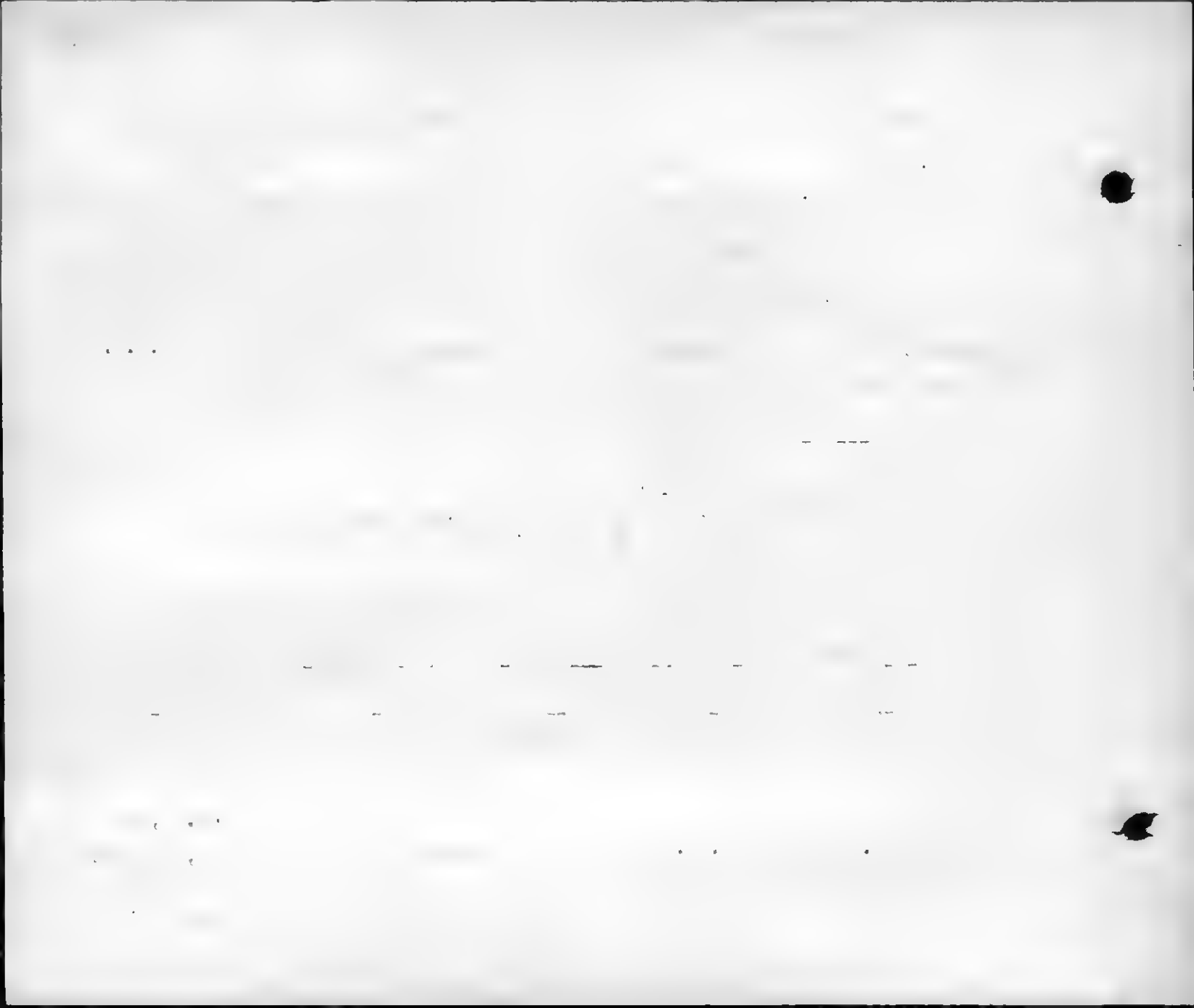


13387

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13327

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6 yrs 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louise Middle Last Cole				4. DATE OF DEATH Month 12 Day 27 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1883 ?	
9. AGE (In years lost birthday) 77 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Atison Cole				14. MOTHER'S MAIDEN NAME Lucy ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Address Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Brain Syndrome associated with General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 45 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) factory, street, office, etc.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/23 to 12/27 , 19 60 , that (I) (we) last saw the deceased alive on 12/27 19 60 , and that death occurred at 7:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict		M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec. 27, 1960			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/31/60		23c. NAME OF CEMETERY OR CREMATORY 1st Cal. m. p. n.		23d. LOCATION (City, town, or county) (State) Cedar Hill, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. O. L. L.		ADDRESS 1000 ...		25a. REC'D BY REGISTRAR DATE JAN 3 '61		25b. REGISTRAR'S SIGNATURE ...	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

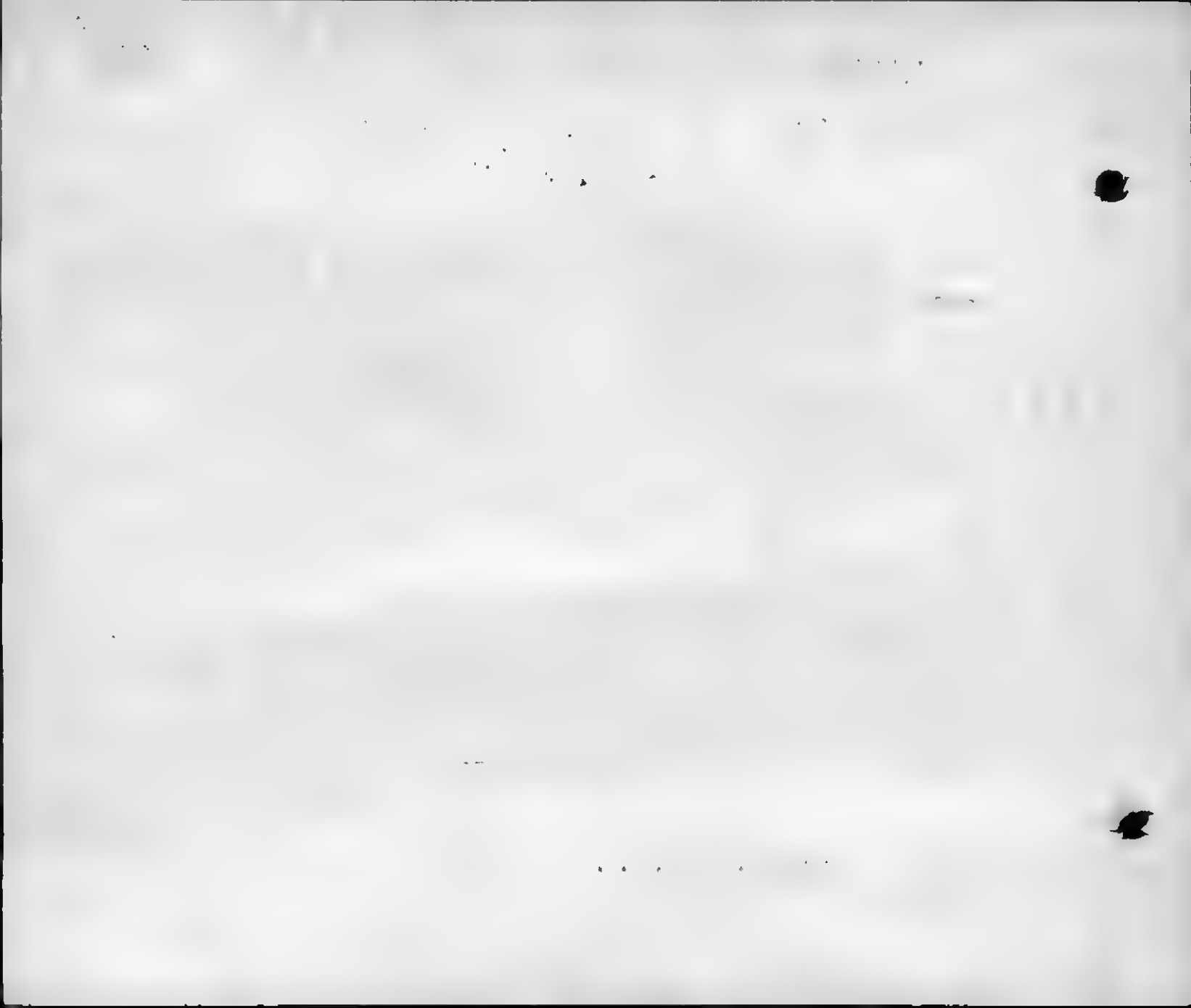
13388 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13329

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship
c. LENGTH OF STAY IN TB
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last
DALE Gail LOUISE CREEK
4. DATE OF DEATH December November 30 19 60
5. SEX Female 6. COLOR OR RACE Colored 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH Nov. 30, 1960
9. AGE (In years last birthday) yrs. 1 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Friendship, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles Creek 14. MOTHER'S MAIDEN NAME Martha Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-uterine Anoxia
7 2.0 XOXOXOX
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonitis due to Amnionitis.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Charles S. Petty M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER ☒ DEPUTY MEDICAL EXAMINER ☐ DATE SIGNED 12/2/60
Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION 22b. DATE THEREOF 12-6-60 22c. NAME OF CEMETERY OR CREMATORY City Morgue 22d. LOCATION (City, town, or country) (State) BALTO. Md
23. FUNERAL DIRECTOR ADDRESS 24a. REC'D BY REGISTRAR DATE DEC 7 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Planch

VS. A15ME
SM 7/59

4000268xv6



13389

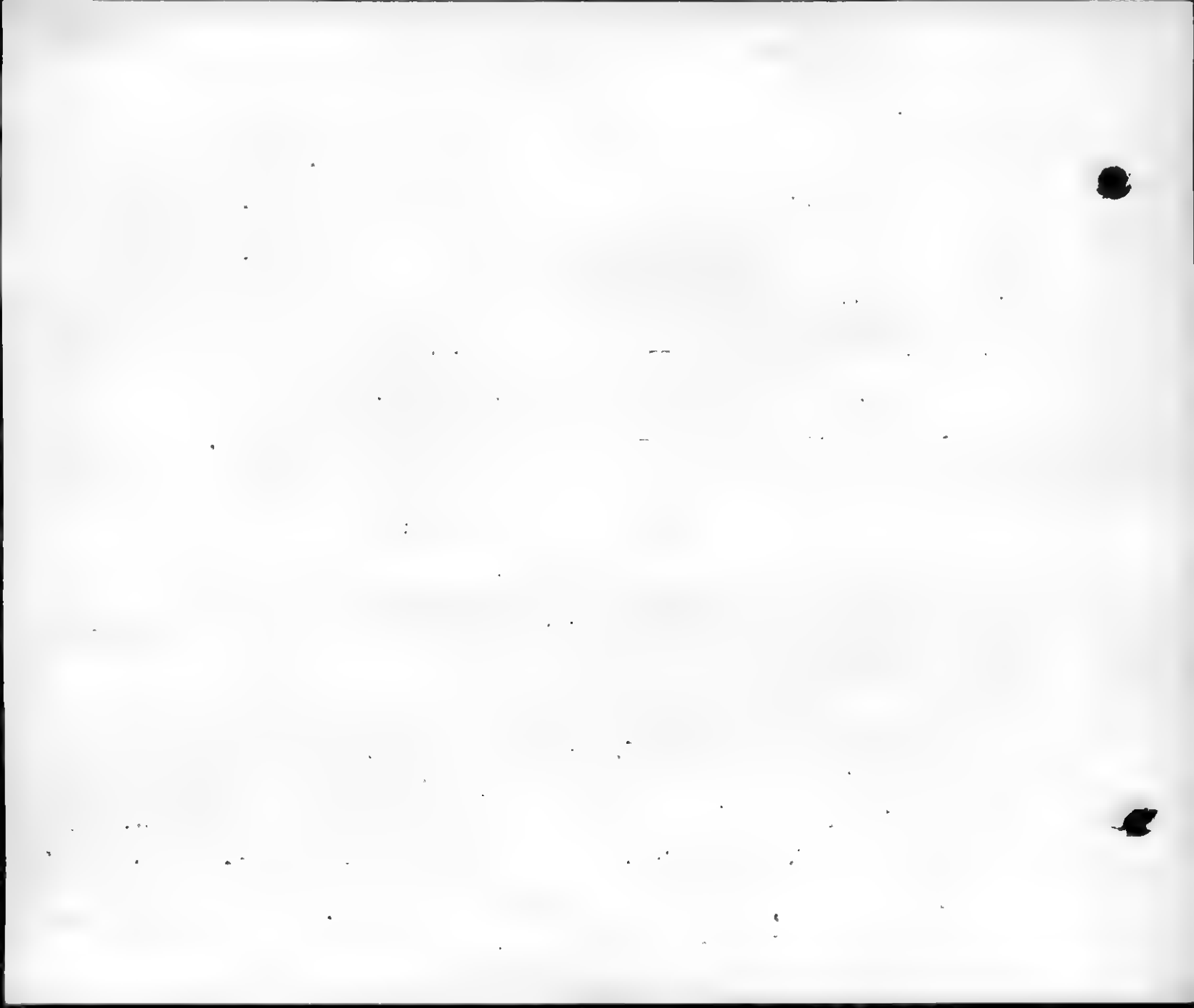
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN 1b 8 years d. NAME OF HOSPITAL, NURSING HOME, OR INSTITUTION District Training School Children's Center		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 1 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 1143 Morse Street N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Veronica Middle Darden Last Darden		4. DATE OF DEATH Month December Day 27 Year 1960	
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1950
9. AGE (In years last birthday) 10 yrs		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min.	IF UNDER 24 HRS Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) D.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME Mary Lee Darden		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---	
16. SOCIAL SECURITY NO. ---		INFORMANT Address Children's Center, Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration DUE TO Severe spastic quadriplegia (b) Convulsive disorder DUE TO --- (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe mental retardation			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/11/52 , 19 52 , to December 27, 1960 , that I last saw the deceased alive on 12/26/60 , 19 60 , and that death occurred at 12.30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED 12/27/60			
ACTUAL SIGNATURE James E. Boyland M.D.		PHYSICIAN'S NAME (Type) James E. Boyland, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 30, 1960	22c. NAME OF CEMETERY OR CREMATORY District Training School
22d. LOCATION (City, town, or county) Laurel		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John DeWester and Son D.T.S.		24a. REC'D BY REGISTRAR JAN 4 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

14
FOR STATE
HEALTH DEPT.

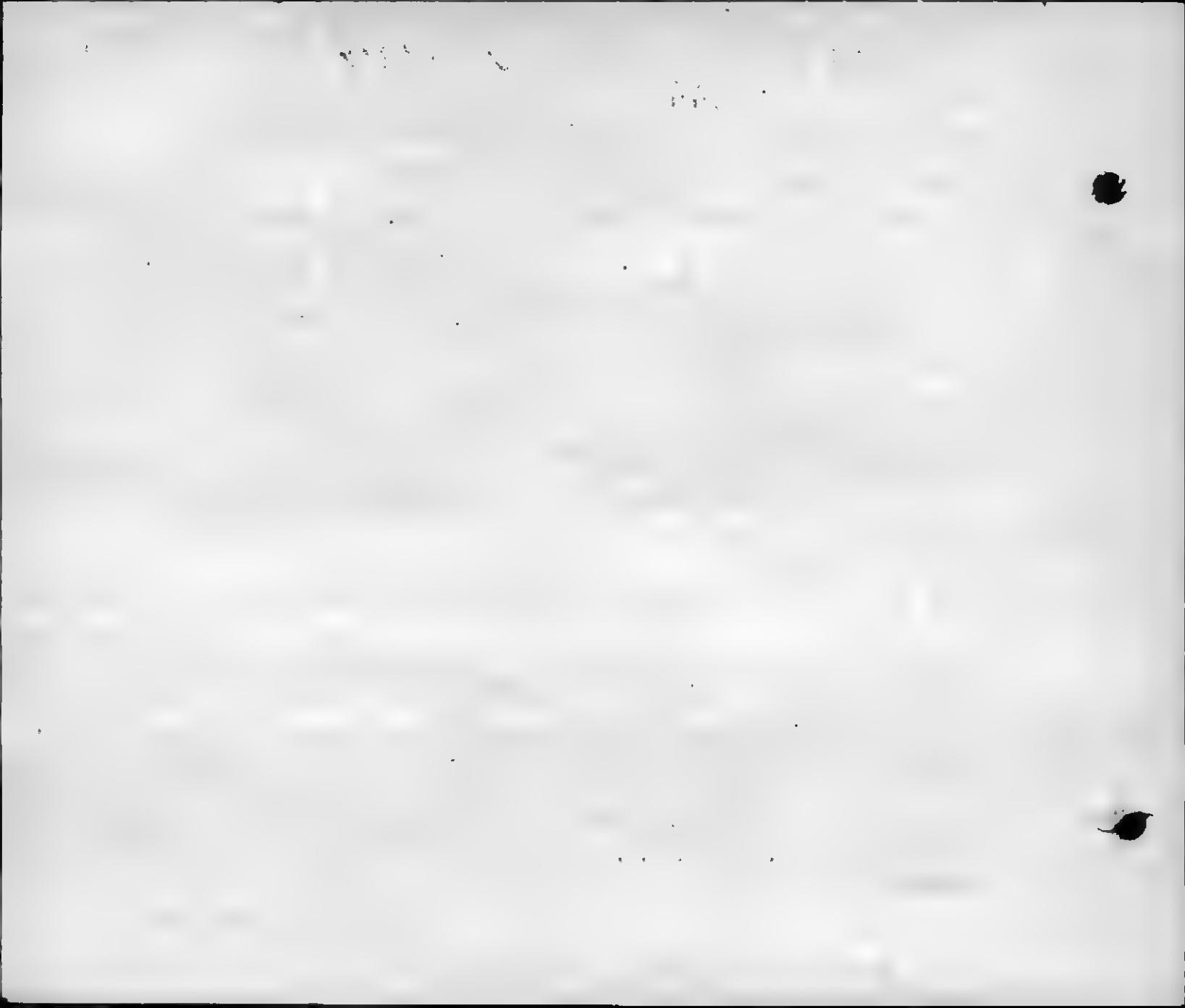
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13331									
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>					c. LENGTH OF STAY IN 1b <u>8 years</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>103 Glenmount Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Richard Dorsey Davis</u>					4. DATE OF DEATH <u>December 14 1960</u>				
5. SEX <u>M</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>10/4/11</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clark and Loyer at H. Jensen Co.</u>					11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				
13. FATHER'S NAME <u>Richard D. Davis Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Iola Marie Morris</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>216-05-9845</u>				
17. INFORMANT <u>Mr. R. Davis (wife)</u>					Address <u>103 Glenmount Ave</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>163x</u> (a), stating the underlying cause last. DUE TO (c) <u>163x</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>163x</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> at work or Not While <input type="checkbox"/> at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Gustave H. Pauley</u>					CHIEF MEDICAL EXAMINER				
EXAMINER'S NAME (Type) <u>Gustave H. Pauley</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Dec 19-60</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Linden Hill Cemetery</u>					22d. LOCATION (City, town, or county) (State) <u>Frederick Md</u>				
23. FUNERAL DIRECTOR <u>Benjamin A. Link</u>					24. REC'D BY REGISTRAR <u>Charles S. Kline</u>				
24b. REGISTRAR'S SIGNATURE					DATE <u>DEC 19 '60</u>				



VS. A15ME
5M 7/59

MEDICAL CERTIFICATE MON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

13344

13333

13344

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>6 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Louis</u> Last <u>DICKINSON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>16 Jan., 1895</u>	
9. AGE (In years last birthday) <u>65</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. Printing Office</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Massachusetts</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Lewis Augustus Dickinson</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Rebecca Cooley</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes WWI</u>			
16. SOCIAL SECURITY NO <u>Yes</u>				17. INFORMANT <u>Irena Barden Dickinson, Same as 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic Acidosis</u> DUE TO (c) <u>Diabetes Mellitus</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 minutes</u> <u>24 hours</u> <u>20 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) <u>physician</u> attended the deceased from <u>Dec. 29, 1960</u> to <u>Dec. 29, 1960</u> , that (I) <u>yes</u> last saw the deceased alive on <u>Dec. 29, 1960</u> , and that death occurred at <u>9:10 P.M.</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>R. I. Hockman</u>				22b. DATE SIGNED <u>12/30/60</u>		22c. PHYSICIAN'S NAME (Type) <u>R. I. Hockman</u>	
22d. ADDRESS <u>100 Cathedral St., Annapolis, Md.</u>				22e. ADDRESS <u>100 Cathedral St., Annapolis, Md.</u>			
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 Jan., 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley, Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hinkle</u>	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

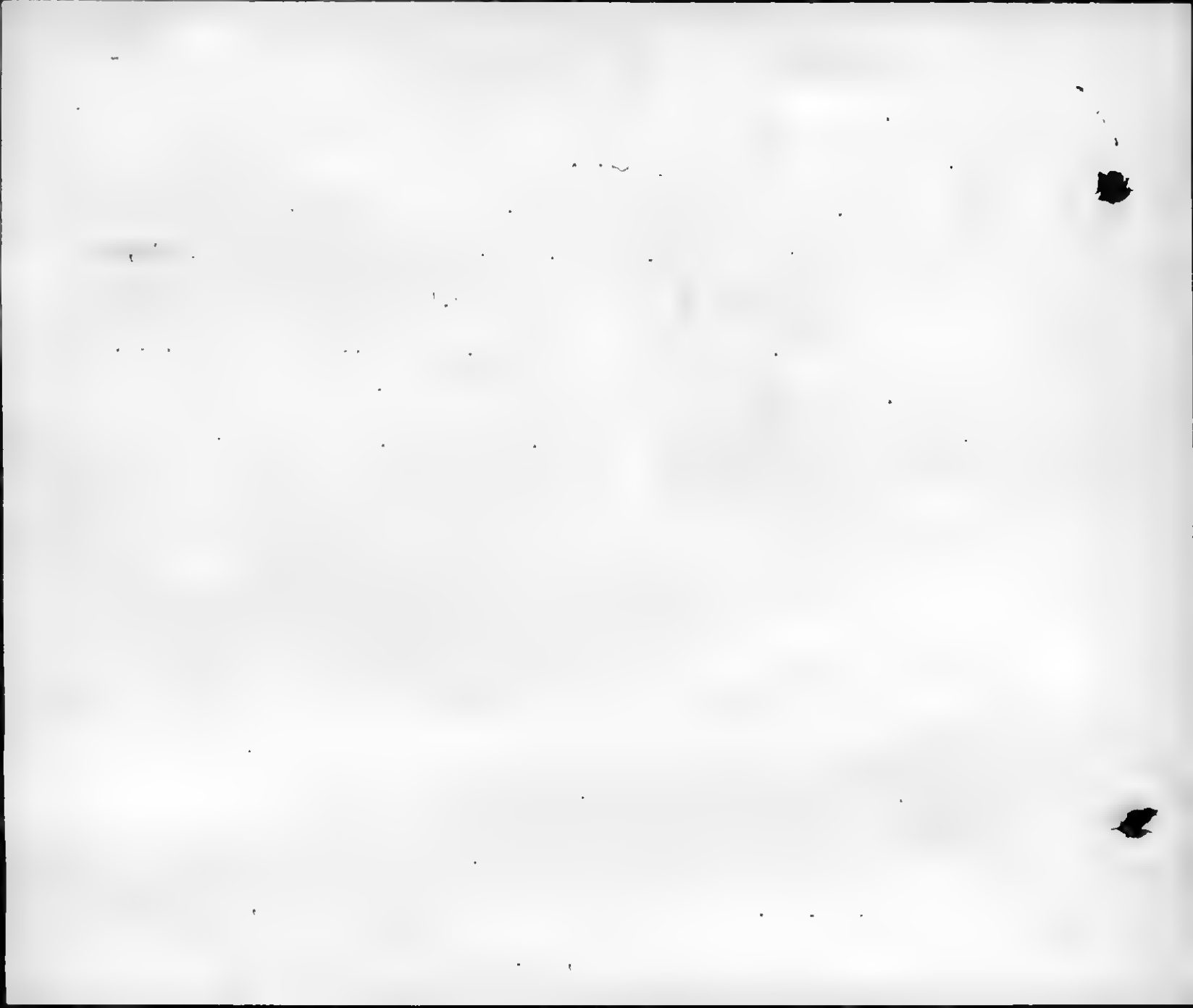
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13391

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover		c. LENGTH OF STAY IN 1b 12 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 121 Rt. 1 Ridge Road				d. STREET ADDRESS Rt. 1 Box 121 Ridge Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First EVA		Middle C.		Last DUCKWORTH		4. DATE OF DEATH Month December Day 11 , 18, 19 Year 60	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17th Nov. '72		9. AGE (In years last birthday) 88 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Garrett Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse O. Fazenbaker				14. MOTHER'S MAIDEN NAME Margaret Ormond					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Mrs. Margaret E. Matthews		Address Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 772.4 DUE TO Acute Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 19 52 to December 19 60 , that (I) (we) last saw the deceased alive on Dec. 11, 1960 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Charles R. MacDonell M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Dec 11 1960			
22c. PHYSICIAN'S NAME (Type) Charles R. MacDonell		22d. ADDRESS Glen Burnie, Md.							
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF 21 st. Dec. '60		23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City, town, or county) Westernport, Maryland (State)			
24. FUNERAL DIRECTOR'S SIGNATURE R. D. Wright		ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE DEC 21 '60		25b. REGISTRAR'S SIGNATURE Charles S. Frank			

B. R.



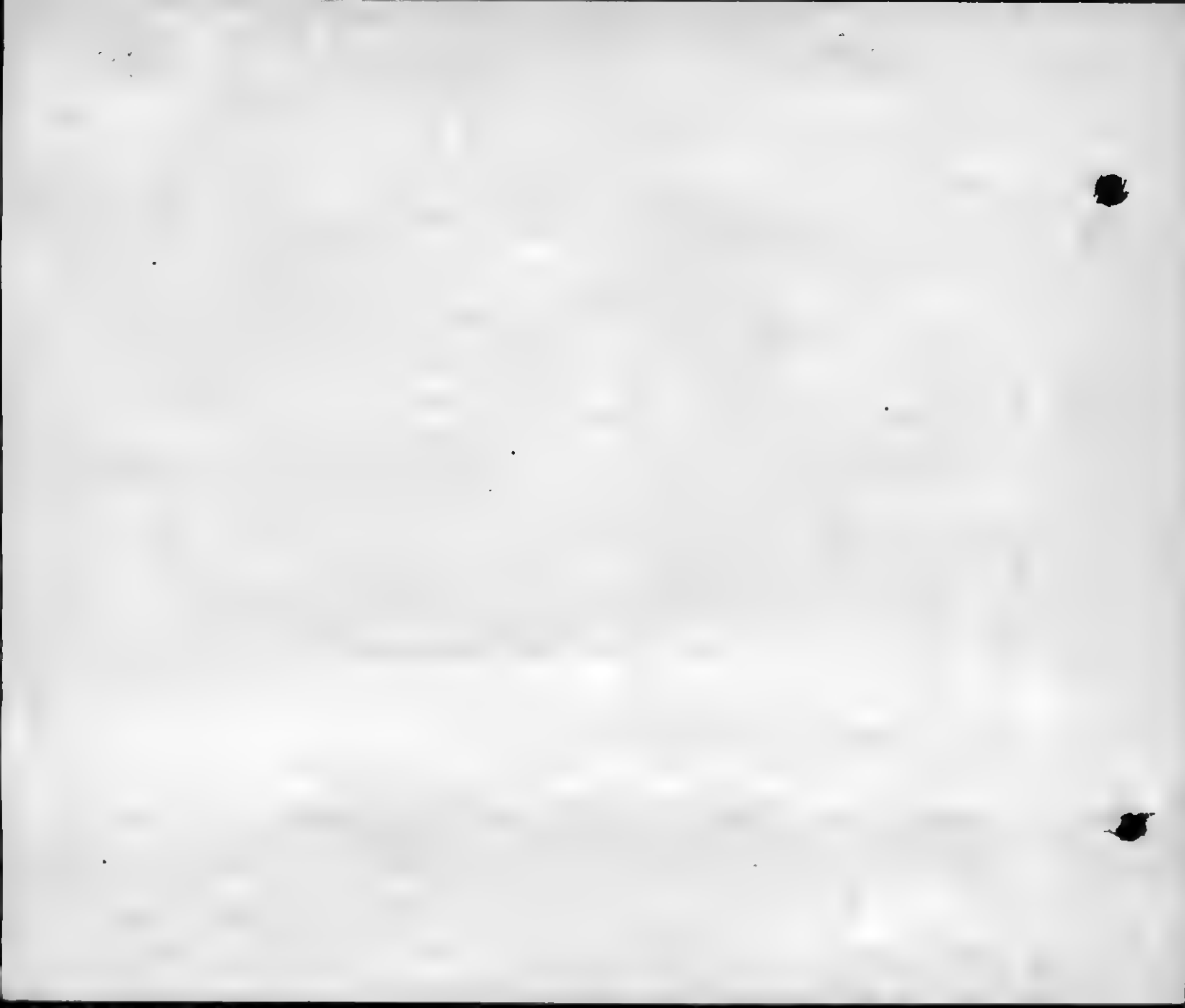
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

13392 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13335

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>5. BALTIMORE</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>1</u>					
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shore</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Glen Burnie Elgin</u>				4. DATE OF DEATH <u>December 19th, 1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/19 8/5/60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Key West, Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Jimmy D. Elgin</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				17. INFORMANT <u>Mrs. Jimmy Elgin (mother)</u>					
16. SOCIAL SECURITY NO. <u>None</u>				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary infection.</u> 527.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Gustave N. Paubert, Jr.</u>				M.D. <u>12/19/60</u>					
EXAMINER'S NAME (Type) <u>Gustave N. Paubert, Jr.</u>				DATE SIGNED <u>12/19/60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>12-20-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem.</u>			
23. FUNERAL DIRECTOR <u>Hopping & Birtley</u>				22d. LOCATION (City, town, or country) <u>Glen Burnie, Md.</u>		22e. (State) _____			
24a. REC'D BY REGISTRAR <u>DEC 23 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13394 **CERTIFICATE OF DEATH**

13336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Ferndale)</u> c. LENGTH OF STAY IN 1b <u>Yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>509 Old Annapolis Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie (Ferndale)</u> d. STREET ADDRESS <u>509 Old Annapolis Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marian</u>		First <u>Marian</u> Middle <u>Fink</u> Last <u>Fink</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 Aug 1898</u>		9. AGE (In years last birthday) <u>82</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Charles Turner</u>				
14. MOTHER'S MAIDEN NAME <u>Ellen (unknown)</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				
16. SOCIAL SECURITY NO. <u>None</u>			INFORMANT <u>Elmer F. Fink</u>				
17. ADDRESS <u>Same As #2</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> (b) <u>Cardiac Insufficiency</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>12-15, 1960</u> to <u>12-16, 1960</u> , that I last saw the deceased alive on <u>12-15, 1960</u> , and that death occurred at <u>6 P.</u> M. from the causes and on the date stated above. ACTUAL SIGNATURE <u>Eugene Schritzer</u> DATE SIGNED <u>12-16-60</u> PHYSICIAN'S NAME (Type) <u>Eugene Schritzer</u> <u>3904 S. Hanover St.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>20 Dec. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Brooklyn RFD, Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Singleton</u>					
24a. REC'D BY REGISTRAR <u>DEC 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13395

CERTIFICATE OF DEATH

13337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel		c. LENGTH OF STAY IN Ib 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION District Training School Children's Center				d. STREET ADDRESS 330 - 16th Street S.E.			
3. NAME OF DECEASED (Type or print) First Barbara Middle Venette Last Fleet				4. DATE OF DEATH Month December Day 29 Year 1960			
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1960		9. AGE (In years lost birthday) 10 yrs.	IF UNDER 1 YEAR Months 11 Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Institutionalized		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Carl Hubert Fleet				14. MOTHER'S MAIDEN NAME Gladys Rebecca Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		INFORMANT Address Children's Center, Laurel, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus 344X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1/60 , 19 to 12/29/60 , 19, that I last saw the deceased alive on 12/28/60 , 19, and that death occurred at 5:30A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. Boyland				ADDRESS (Street, city or town, state) Children's Center, Laurel, Md.			
PHYSICIAN'S NAME (Type) James E. Boyland, M.D.				DATE SIGNED 12/29/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 3, 1961		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY AR LINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) FT. MYER, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter H. Pope		ADDRESS 414-15th S.E.		24a. REC'D BY REGISTRAR JAN 3 '61		24b. REGISTRAR'S SIGNATURE Arthur E. H.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13396

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13338

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 7mo. 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3. V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 4432 St. George Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Edwin Last Fletcher				4. DATE OF DEATH Month 12 Day 9 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1903	
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months 57 Days 12 Hours 9 Min.		11. IF UNDER 24 HRS. Months 57 Days 12 Hours 9 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John M. Fletcher				14. MOTHER'S MAIDEN NAME Mary E. Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-1150		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO 026X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) C.B.S. Assoc. & N.S. Syphilis DUE TO Gastroenteromy (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----						INTERVAL BETWEEN ONSET AND DEATH Sudden Since Admission	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While Not at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, school, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/19 , 19 60 , to 12/9 , 19 60 , that (I) (we) last saw the deceased alive on 12/9 , 19 60 , and that death occurred at 12AM , from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict, M. D.				22b. DATE 12/9/60		22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.	
22d. ADDRESS Crownsville State Hospital, Maryland							
23a. BURIAL, CREMATION, OR DISPOSITION (Specify) Burial		23b. DATE THEREOF 12-13-60		23c. NAME OF CEMETERY OR CREMATORY Int. Calvary Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Run				25a. REC'D BY REGISTRAR 2222 W. North Ave		25b. REGISTRAR'S SIGNATURE Christina S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

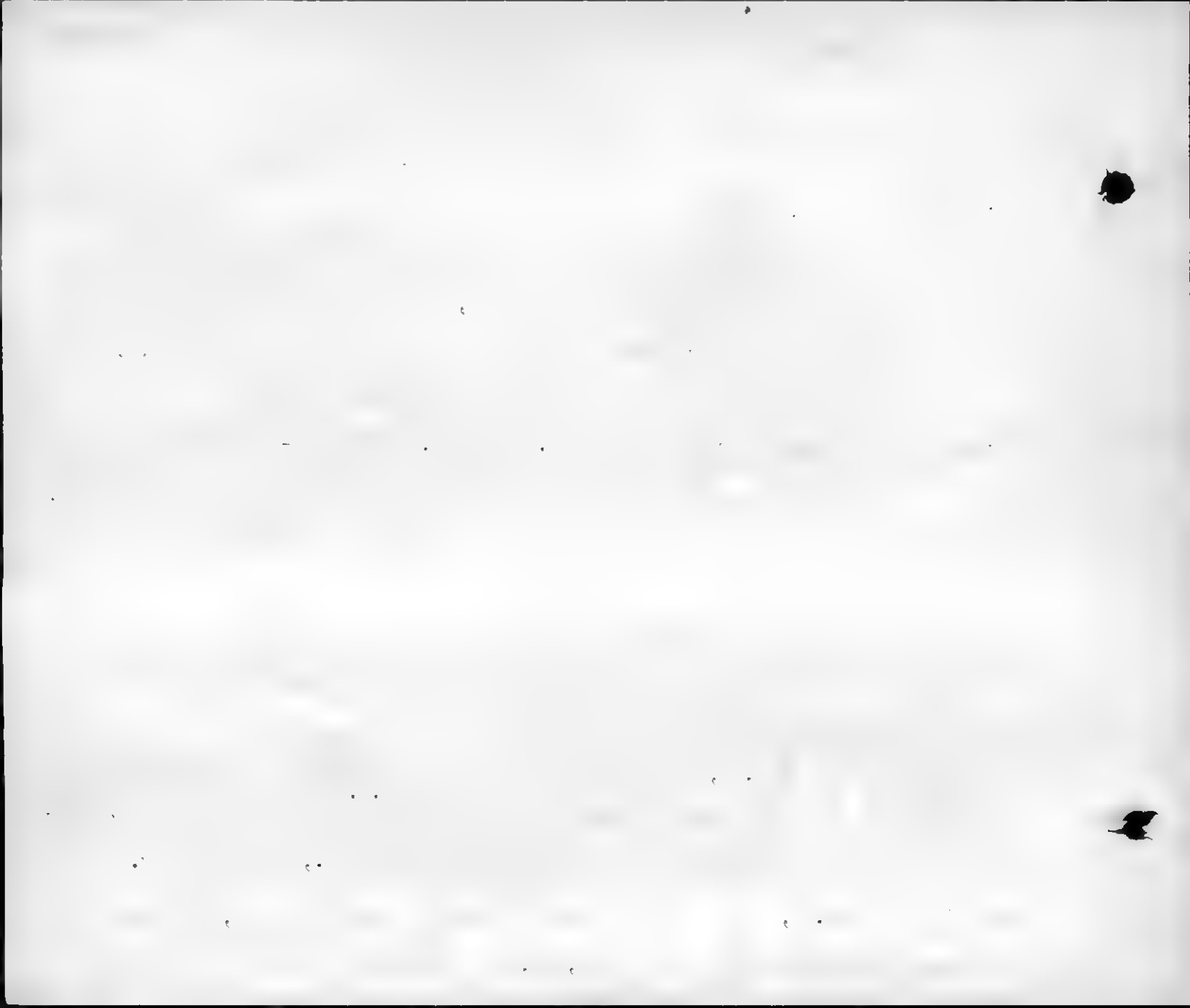
VR A15 (4)
15M 9/59

13345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13339

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Bertha Middle E Last FORNEY				4. DATE OF DEATH Month December Day 1 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 3, 1879			
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME John Catterton				14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none					
17. INFORMANT Mr. Robert L. Forney-Son- Same as # 2				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 274X IMMEDIATE CAUSE (a) ac. Arterial insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chr. Arterial insufficiency DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Plumicins anemia. Thyroid insufficiency								INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) physician attended the deceased from November 1959 to Dec. 1, 1960 , that (I) last saw the deceased alive on Dec. 1, 1960 , and that death occurred at 11:45 P.M. from the causes and on the date stated above									
22a. SIGNATURE Maurice Klawns				22b. DATE SIGNED 12/2/60					
22c. PHYSICIAN'S NAME (Type) Maurice Klawns				22d. ADDRESS 31 Southgate Ave., Annapolis, Md.					
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 5, 1960		23c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Millersville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				25a. REC'D BY REGISTRAR DEC 7 '60		25b. REGISTRAR'S SIGNATURE William S. Kraus			



1
FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. If the deceased was 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

19940
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13374 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adenton</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adenton</u>			
c. LENGTH OF STAY IN 1b <u>1 Year</u>				d. STREET ADDRESS <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>"Egan Town" Annapolis Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>George Gazda</u>				4. DATE OF DEATH <u>12/19/60</u>			
5. SEX <u>M</u>				6. DATE OF BIRTH <u>5/5/14</u>			
6. COLOR OR RACE <u>White</u>				7. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed, manager of bar.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Bar</u>			
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Gazda</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>15-11-60000</u>			
17. INFORMANT <u>Glenn Burnie</u>				Address <u>Adenton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation by smoke</u> DUE TO (b) <u>None</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Insisted upon going into hotel while in flames.</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>None</u> minutes							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>None</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Insisted upon going into hotel while in flames.</u>							
20c. TIME OF INJURY Month, Day, Year <u>12/19/60</u> 19 <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hotel (main floor)</u>				20f. (City or town) <u>Adenton</u> (County) <u>Anne Arundel</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Glenn Burnie</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Glenn Burnie</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>12-23-60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Homestead Cemetery</u>				22d. LOCATION (City, town, or country) <u>Homestead</u> (State) <u>PA.</u>			
23. FUNERAL DIRECTOR <u>Hopping & Kirkley</u>				24a. REC'D BY REGISTRAR <u>Glenn Burnie</u>			
ADDRESS <u>Glenn Burnie, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>William S. Kenna</u>			
DATE DEC 23 '60							



13346

CERTIFICATE OF DEATH

13341

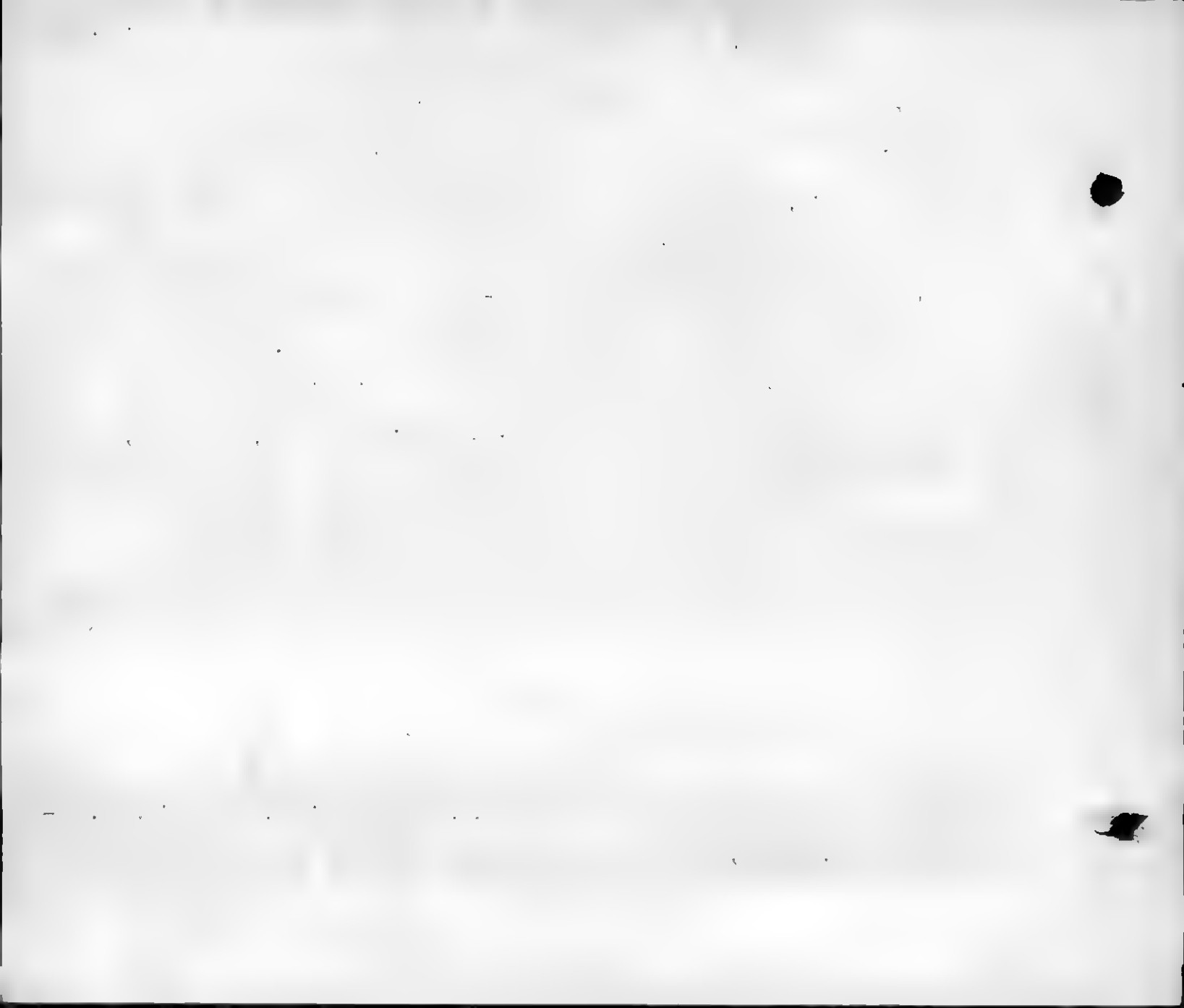
Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, Annapolis, Maryland				d. STREET ADDRESS Wilellinor Estates			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Karen Elizabeth GRANT		4. DATE OF DEATH Month Day Year December 5th 1960					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-60	9. AGE (In years lost birthday) 00 yrs.	IF UNDER 1 YEAR Months Days 00 02	IF UNDER 24 HRS. Hours Min. 00 02	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Carleton Grant				14. MOTHER'S MAIDEN NAME Susan Ann Reichel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Father - Wilellinor Estates, Edgewater, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS OF LUNGS 76-00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/3 , 19 60 , to 12/5 , 19 60 , that I last saw the deceased alive on 12/5 , 19 60 , and that death occurred at 2:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE N. L. ZOURAS, LT MC USNR				M.D. U.S. Naval Hospital, Annapolis, Md. 12-6			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		12-6-60		U.S. Naval Academy		Annapolis Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				24a. REC'D BY REGISTRAR DEC 8 '60		24b. REGISTRAR'S SIGNATURE Charles L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051212XV3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13397

13342

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural-Pasadena		c. LENGTH OF STAY IN 1b 35 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		d. STREET ADDRESS Box 185 Route 2 Rock Creek	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle MILTON Last GRAY		4. DATE OF DEATH Month December Day 5th Year 1960	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1886
9 AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min.	IF UNDER 24 HRS Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Helper		10b. KIND OF BUSINESS OR INDUSTRY Gen'l House Reprs. Anne Arundel Co Md	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm C Gray		14. MOTHER'S MAIDEN NAME Elizabeth F Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-7177	
17. INFORMANT Mrs May L Gray (Wife-Widow)		Address SAME	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebro-vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) generalized arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 hours 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) none	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (his hospital) attended the deceased from June 10, 1954 to Dec 5, 1960 , that (I) (lost) saw the deceased alive on Dec 1, 1960 , and that death occurred at 6 AM , from the causes and on the date stated above.			
22a. SIGNATURE R.M. McLaughlin		22b. DATE 12/5/60	
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin		22d. ADDRESS 3708 Mountain Rd. Pasadena Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC 8 1960	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	23d. LOCATION (City, town, or county) (State) Brooklyn AA Co Md
24. FUNERAL DIRECTOR'S SIGNATURE A. Howard Evans & Son		25a. REC'D BY REGISTRAR DEC 6 '60	
25b. REGISTRAR'S SIGNATURE Carl G. Evans			



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

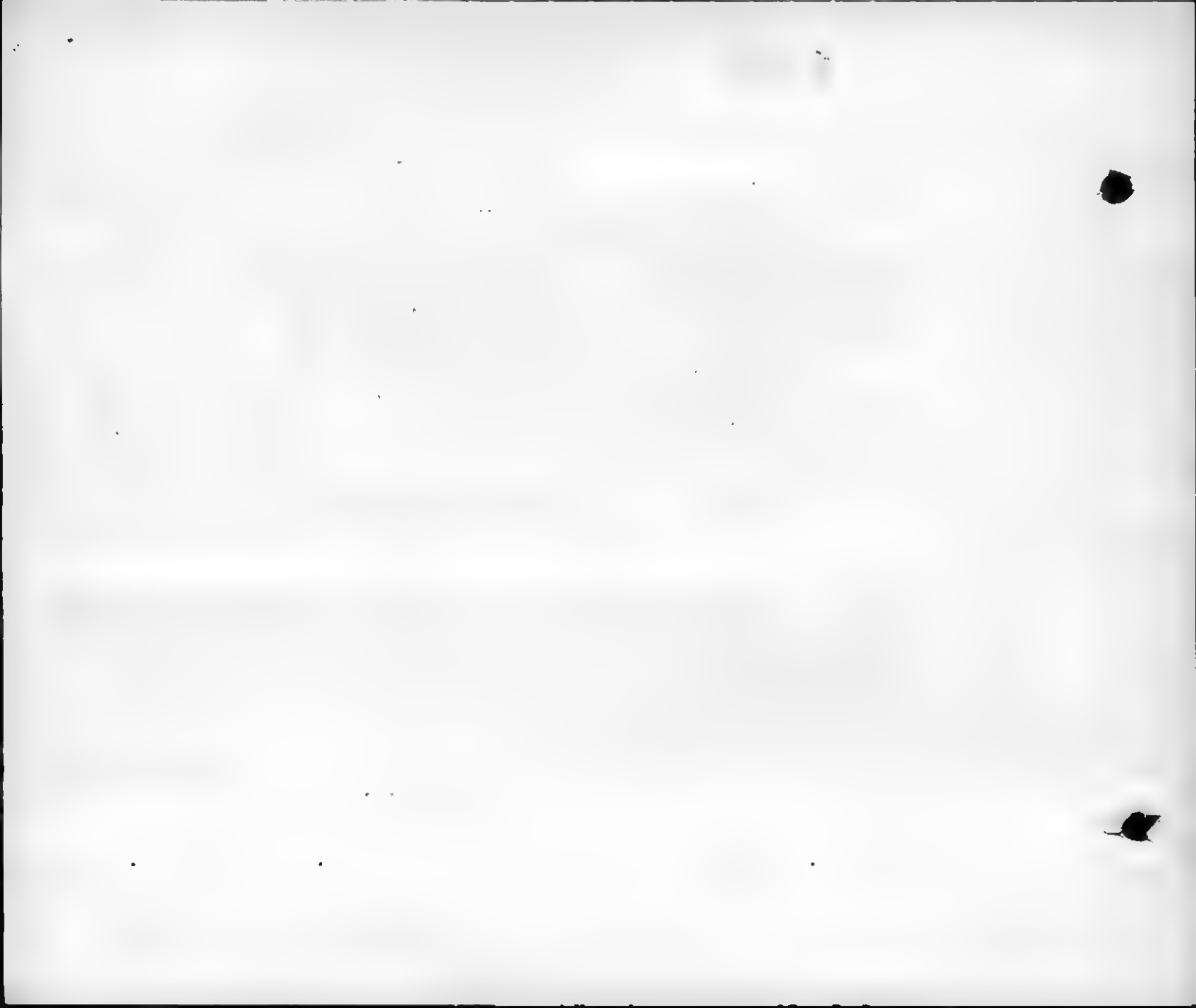
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13347

CERTIFICATE OF DEATH

13343

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital		d. STREET ADDRESS Rt-1, Bon Haven	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mario Middle P Last GRAZIOLI		4. DATE OF DEATH Month December Day 12 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 20, 1911
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 49 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept of Defense at Ft Meade Md		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Dominic Gargioli		14. MOTHER'S MAIDEN NAME Maria Endrizzzi	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO —	
17. INFORMANT Geraldine L. Gargioli		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Cerebral myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) — DUE TO — (c) —		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) John L. Hedeman attended the deceased from Jan 1960 to Dec 1960 , that (I) last saw the deceased alive on July 1 19 60 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John L. Hedeman		22b. DATE SIGNED DEC 15 '60	
22c. PHYSICIAN'S NAME (Type) John L. Hedeman		22d. ADDRESS 121 Cathedral St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 16-1960	
23c. NAME OF CEMETERY OR CREMATORY St Marys		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Scyler-Sims		25a. REC'D BY REGISTRAR DEC 15 '60	
ADDRESS Annapolis Md		25b. REGISTRAR'S SIGNATURE Geraldine L. Gargioli	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar for burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13348

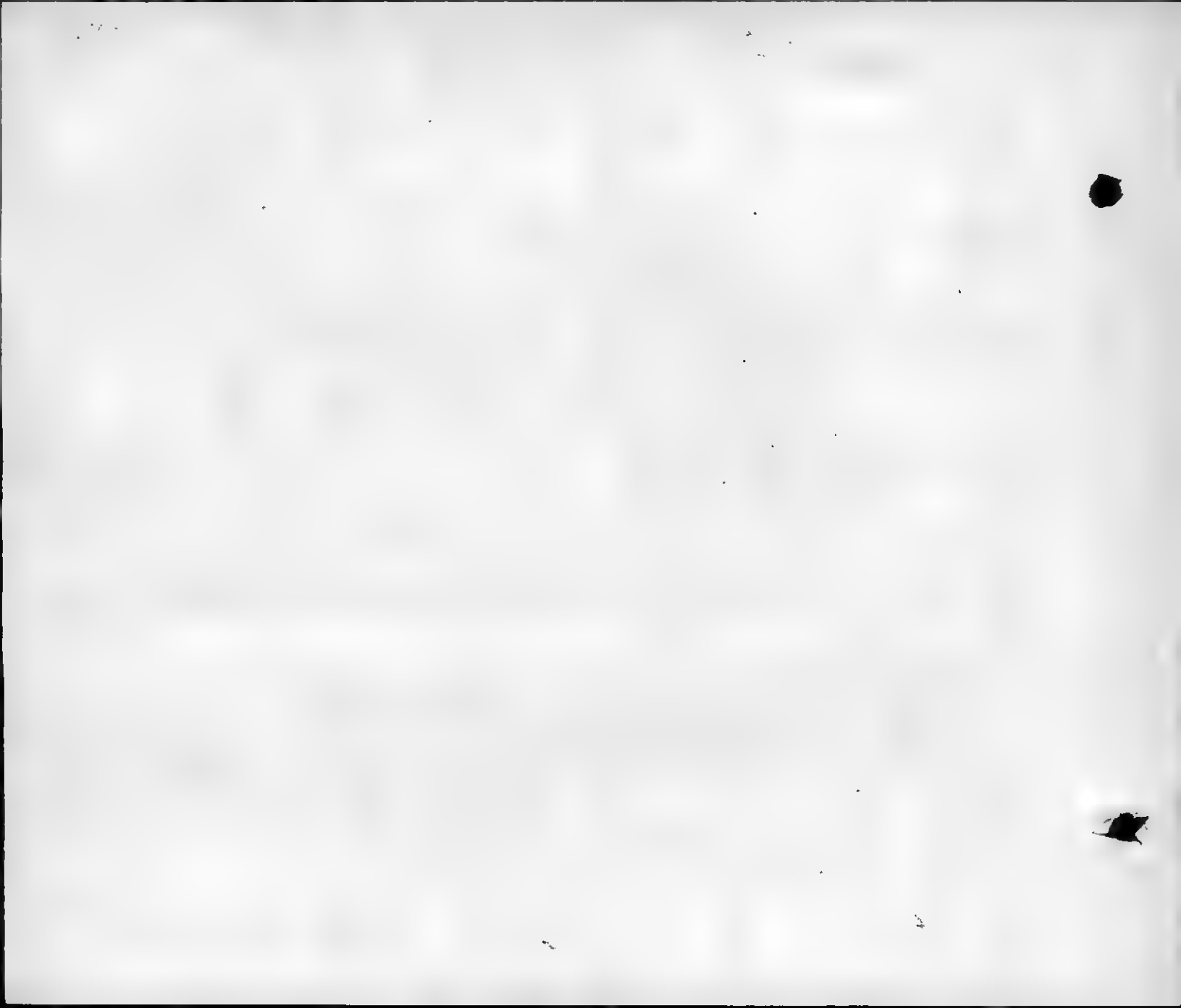
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film 6276 12-18-60 et

13344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. General Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilhelmina Estates</u> d. STREET ADDRESS <u>1 R.D. # 2 Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Terry Saxon Green III</u> First Middle Last		4. DATE OF DEATH <u>12-6-1960</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 3-1930</u>	9. AGE (In years last birthday) <u>30</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marketing Ordance Dept Westinghouse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St Paul Minn.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Terry S. Green II</u>		14. MOTHER'S MAIDEN NAME <u>Jacqueline Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes 1950-58</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Pauline B. Green</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> 725 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>725</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Auto accident</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>12:10 a.m. 12/6 1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>At. 50</u>	20f. (City or town) <u>AA</u>	(County) <u>MD</u>	(State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>E. L. Howard</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-6-60</u>	
EXAMINER'S NAME (Type) <u>E. L. Howard</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-9-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) <u>Arlington</u>	(State) <u>Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Seyler Duns</u>		ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Kuma</u>



CERTIFICATE OF DEATH

Reg. Dist. No.

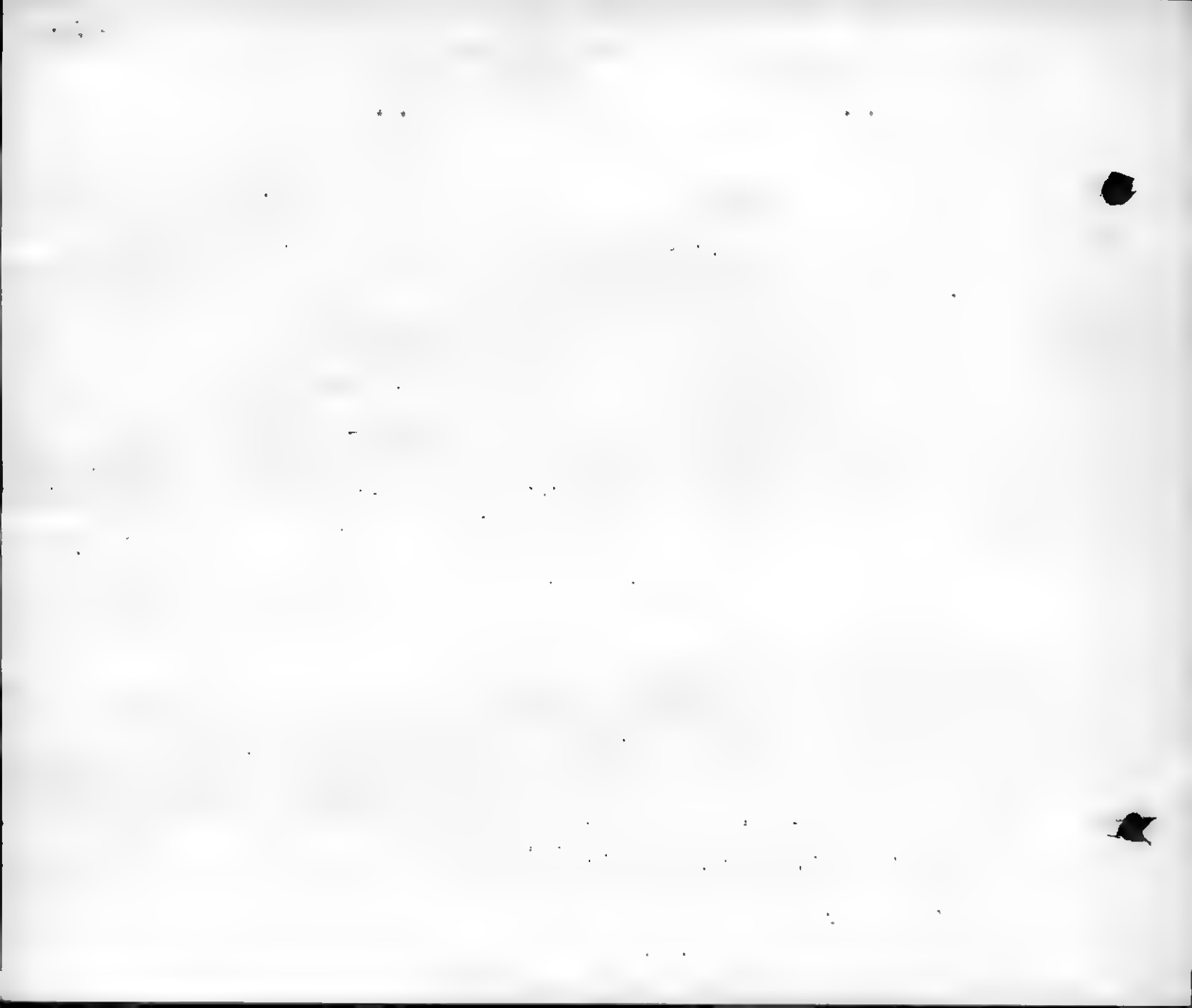
13345

13398

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE A.A. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 BROOKLYN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION III SIXTH AVENUE		d. STREET ADDRESS III SIXTH AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last MATILDA GREGOR		4. DATE OF DEATH Month Day Year 12/6/60 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/84
9. AGE (In years last birthday) yrs. 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME GOTTLIEB NIERNBERG		14. MOTHER'S MAIDEN NAME AUGUSTINA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. INFORMANT Address FAMILY - SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) arterio-sclerotic Cardio-renal disease 5 years DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/25 , 19 57 , to 12/12/60 , 19 60 , that I last saw the deceased alive on 12/5 , 19 60 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Deibel M.D.		ADDRESS (Street, city or town, state) 1226 Hanover St. DATE SIGNED	
PHYSICIAN'S NAME (Type) DR. HARRY DEIBEL			
22a. BURIAL, CREMATION, REMOVAL (Specify) B	22b. DATE THEREOF 12/10/60	22c. NAME OF CEMETERY OR CREMATORY GLEN HAVEN	22d. LOCATION (City, town, or county) (State) BALTIMORE
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS MCCULLY - 130 EAST FORT AVENUE		24a. REC'D BY REGISTRAR DATE DEC 9 '60	24b. REGISTRAR'S SIGNATURE J. L. K...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

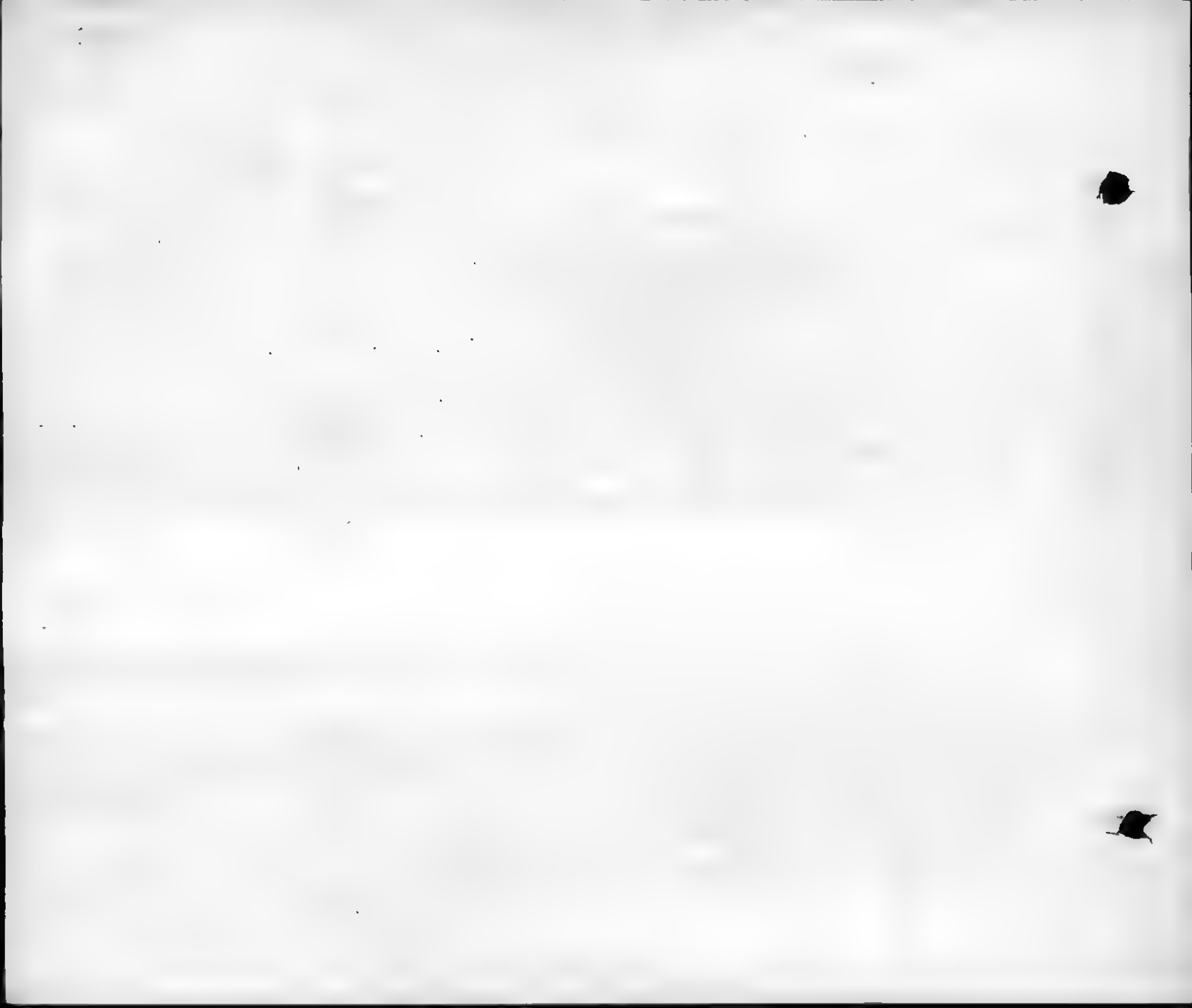


may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13377
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13346

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>A.A. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Orchard Beach</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Orchard Beach</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1210 Beach Promenade</i>		d. STREET ADDRESS <i>1210 Beach</i>	
3. NAME OF DECEASED (Type or print) <i>Waisy T. Griffith</i>		4. DATE OF DEATH <i>Dec. 2/60</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 21, 1888</i>
9. AGE (In years lost birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Corn Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Schrader</i>		14. MOTHER'S MAIDEN NAME <i>Eliz. —</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service,)</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Allen R. Griffith</i>		Address <i>Orchard Beach</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the descending colon</i> DUE TO (b) <i>4 months</i> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (c), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 1, 1955</i> to <i>December 2, 1960</i> , that (I) <i>(lost)</i> saw the deceased alive on <i>December 2, 1960</i> , and that death occurred at <i>9:15 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>R. M. McLaughlin</i> M.D.		22b. DATE SIGNED <i>12/2/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i>		22d. ADDRESS <i>3708 7th Mountain Pl. Pasadena, Md.</i>	
23a. BURIAL, CREMATION, REMOVA (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/6/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven</i>		23d. LOCATION (City, town, or county) (State) <i>Glenburnie, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Witke F. N. 4101 Edmondson</i>		25a. REC'D BY REGISTRAR <i>DEC 5 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>C. S. K. K. K.</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13347

13399

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenland Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 426 Greenland Beach Road		d. STREET ADDRESS 426 Greenland Beach Road	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Mary Beatrice Grass		4. DATE OF DEATH Dec. 26, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 22, 1881
9. AGE (In years last birthday) 79 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.			

13. FATHER'S NAME James McNaney		14. MOTHER'S MAIDEN NAME Julia (Unk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 153.8	
17. INFORMANT Mrs. Alice Germershausen 1239 Battery Ave.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Colon DUE TO 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 153.8 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **Feb 1960** to **Dec 25 1960** that (I) (we) last saw the deceased alive on **12/24/1960**, and that death occurred at **11** M, from the causes and on the date stated above.

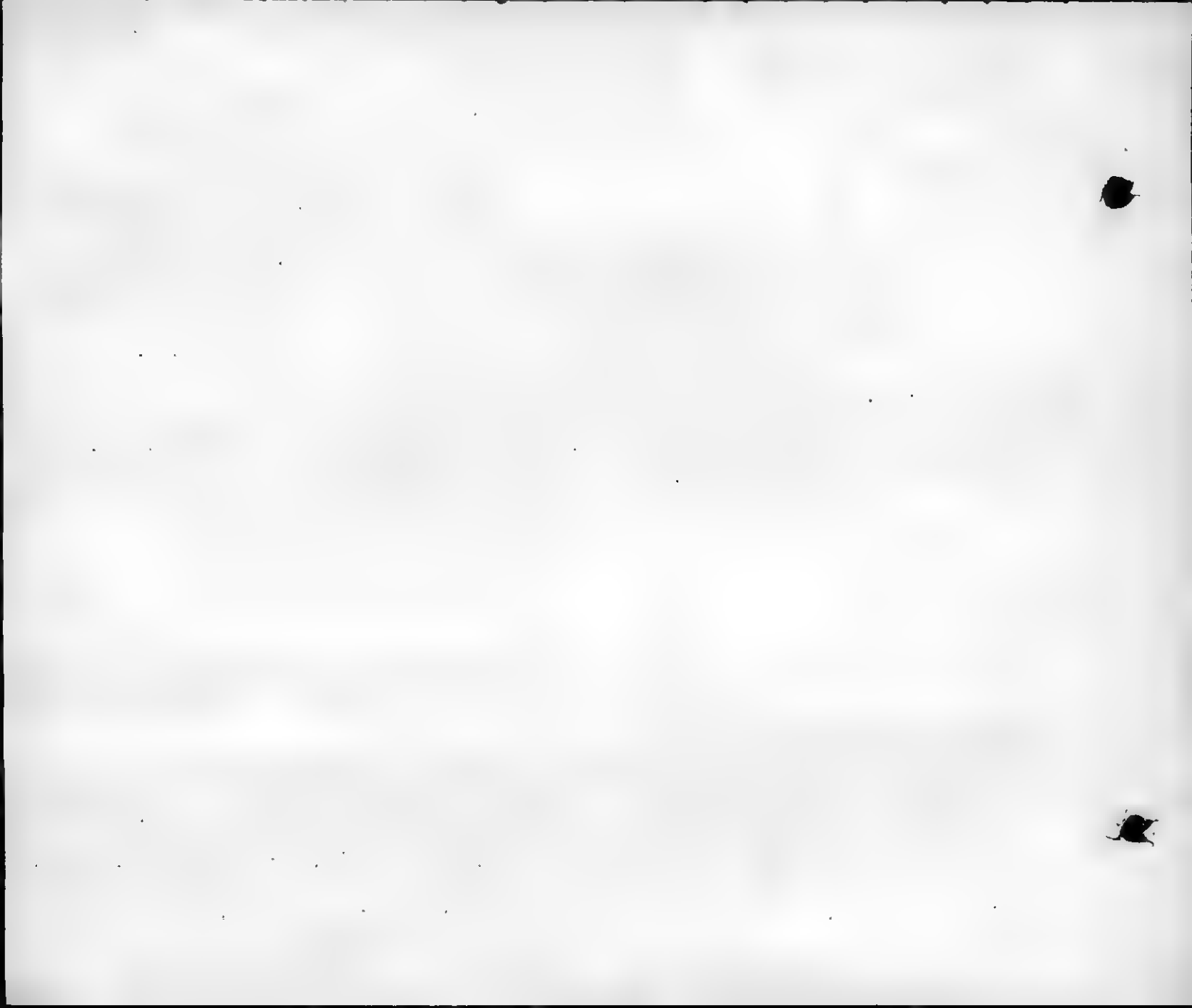
22a. SIGNATURE J. Brady Smith	22b. DATE SIGNED Dec. 26, 1960
22c. PHYSICIAN'S NAME (Type) Brady Smith	22d. ADDRESS Ft. Smallwood Rd. Riviera Beach A. A. Co. Md

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 28, 1960	23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery	23d. LOCATION (City, town, or county) (State) Frederick Road, Baltimore, Md.
--	---	---	--

24. FUNERAL DIRECTOR'S SIGNATURE Krause Funeral Home - 1216 S. Charles St	25a. REC'D BY REGISTRAR DEC 28 '60	25b. REGISTRAR'S SIGNATURE Charles E. Krause
---	--	--

Doris P. Krause

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



13349

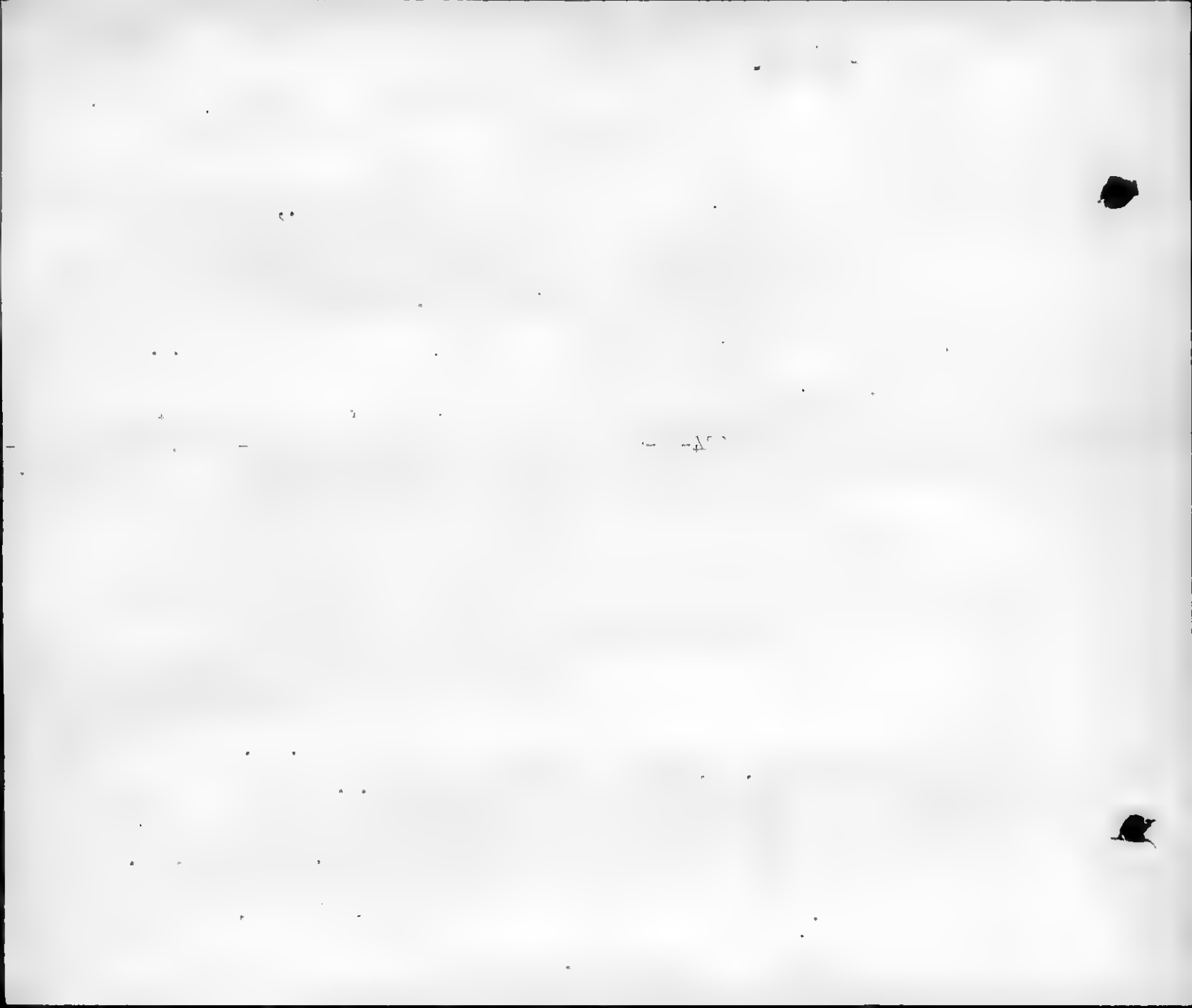
CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13348

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle May Last HARLEY		4. DATE OF DEATH Month December Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1903
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaners	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Walter Phipps		14. MOTHER'S MAIDEN NAME Maude McCoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) n (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 216-05-0766	
17. INFORMANT James Dudley Phipps, Brother- Adml, Hgts, Annapo-		Address 6 Porter Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Valvular, distal ilium DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Germany army disband			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from Dec. 14, 1960 to Dec. 16, 1960 , that (I) last saw the deceased alive on Dec. 16, 1960 , and that death occurred at 11:20 A.M. from the causes and on the date stated above			
22a. SIGNATURE Maurice Klawans		22b. DATE SIGNED 12/16/60	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 20, 1960	
23c. NAME OF CEMETERY OR CREMATORY All Hallows		23d. LOCATION (City, town, or county) (State) Birdsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25a. REC'D BY REGISTRAR DEC 27 '60	
ADDRESS Annapolis, Md		25b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 could be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your office.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13400

13349

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u> c. LENGTH OF STAY IN life <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fort Meade Hospital, Md.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James W. Hartung</u>		4. DATE OF DEATH Month <u>October</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/13/60</u>	9. AGE (in years last birthday) yrs. <u>1</u> Months <u>23</u> Days <u>23</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <u>1</u> Min. <u>23</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Fort Meade Hospital, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>None</u>		13. FATHER'S NAME <u>James W. Hartung</u>		14. MOTHER'S MAIDEN NAME <u>Joan Sullivan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. and Mrs. J.W. Hartung (parents)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> <u>Congenital heart diseases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/5/60</u>	
EXAMINER'S NAME (Type) <u>Gustave F. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8th Dec. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lakeview Cemetery</u>	
22d. LOCATION (City, town, or country) <u>Jamestown, New York</u>					
23. FUNERAL DIRECTOR <u>R. J. Singleton</u>		ADDRESS <u>Glen Burnie, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 7 1960</u>	
24b. REGISTRAR'S SIGNATURE <u>Carol L. Kline</u>					

MEDICAL CERTIFICATION

2

2

XV3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

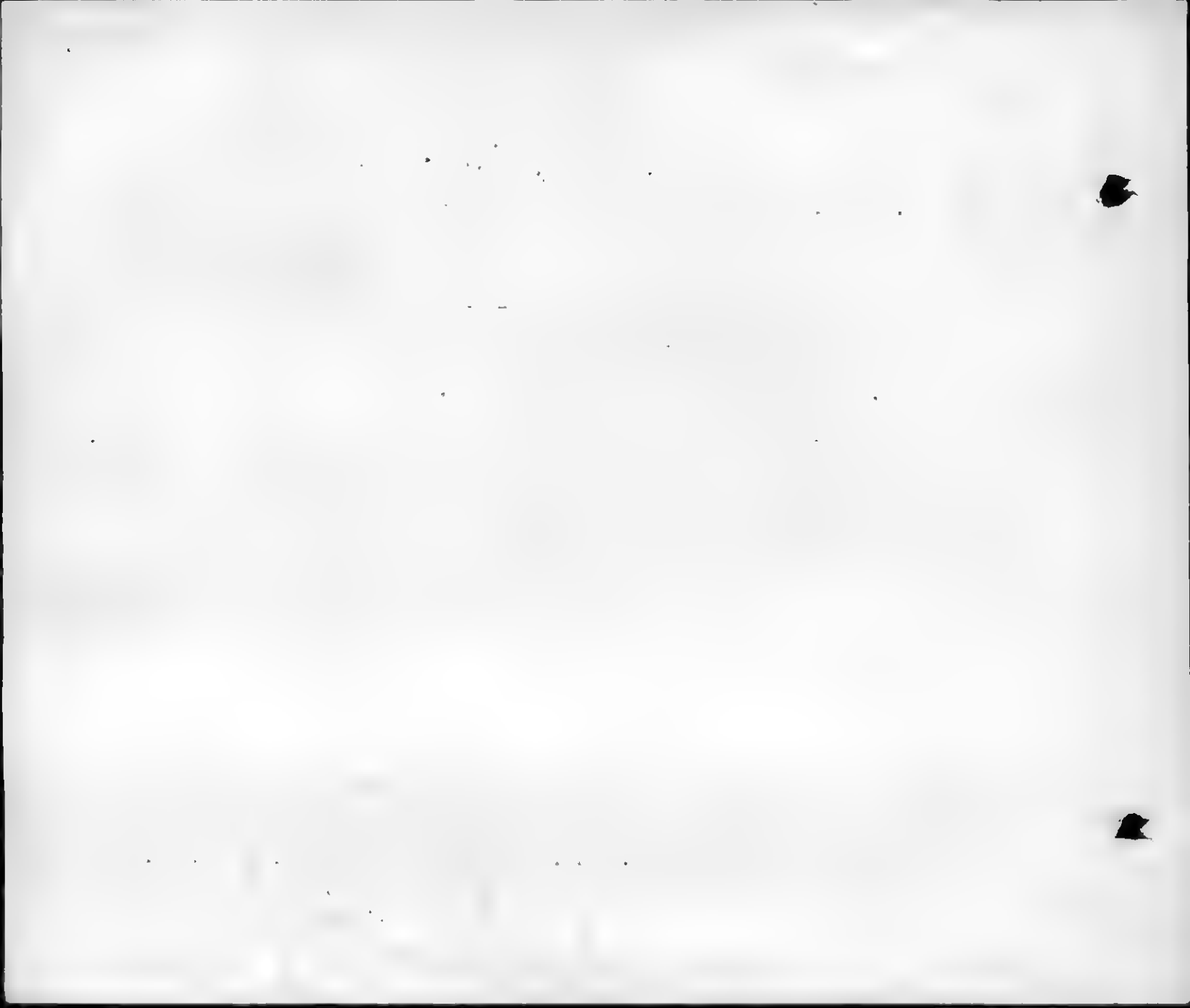
VR A15 (4)
15M 9/59

1
13375
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13350

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton, Md c. LENGTH OF STAY IN 1b United States Army Hospital d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ft Geo. G. Meade, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft. George G. Meade d. STREET ADDRESS 7311-E Gammons e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EVA MARIE Hartwig		4. DATE OF DEATH Month Day Year 12 11 19 60	
5 SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> N/A <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-60
9. AGE (In years last birthday) yrs 28		10. IF UNDER 1 YEAR Months Days 28 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SFC Keith E. Hartwig		14. MOTHER'S MAIDEN NAME Mary E. Hunt	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) - -		16. SOCIAL SECURITY NO. - -	
17. INFORMANT Father		Address 7311-E Gammons Ft Geo G. Meade, Md.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 774X IMMEDIATE CAUSE (a) Respiratory Distress Syndrome DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 26 Hrs 5 Min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10 Dec 1960 to 11 Dec 1960 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 5A.M. from the causes and on the date stated above.			
22a. SIGNATURE Sherman S. Robinson M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22b. DATE SIGNED 11 Dec 60	
22c. PHYSICIAN'S NAME (Type) SHERMAN S. ROBINSON, Capt., M.C.		22d. ADDRESS USA Hosp Ft Geo G. Meade, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec 14, 1960	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl	23d. LOCATION (City, town, or county) (State) Arlington Virginia
24. FUNERAL DIRECTOR'S SIGNATURE DeWitt Donaldson, Laurel, Md		25a. REC'D BY REGISTRAR DATE DEC 15 '60 25b. REGISTRAR'S SIGNATURE Arthur L. Frank	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

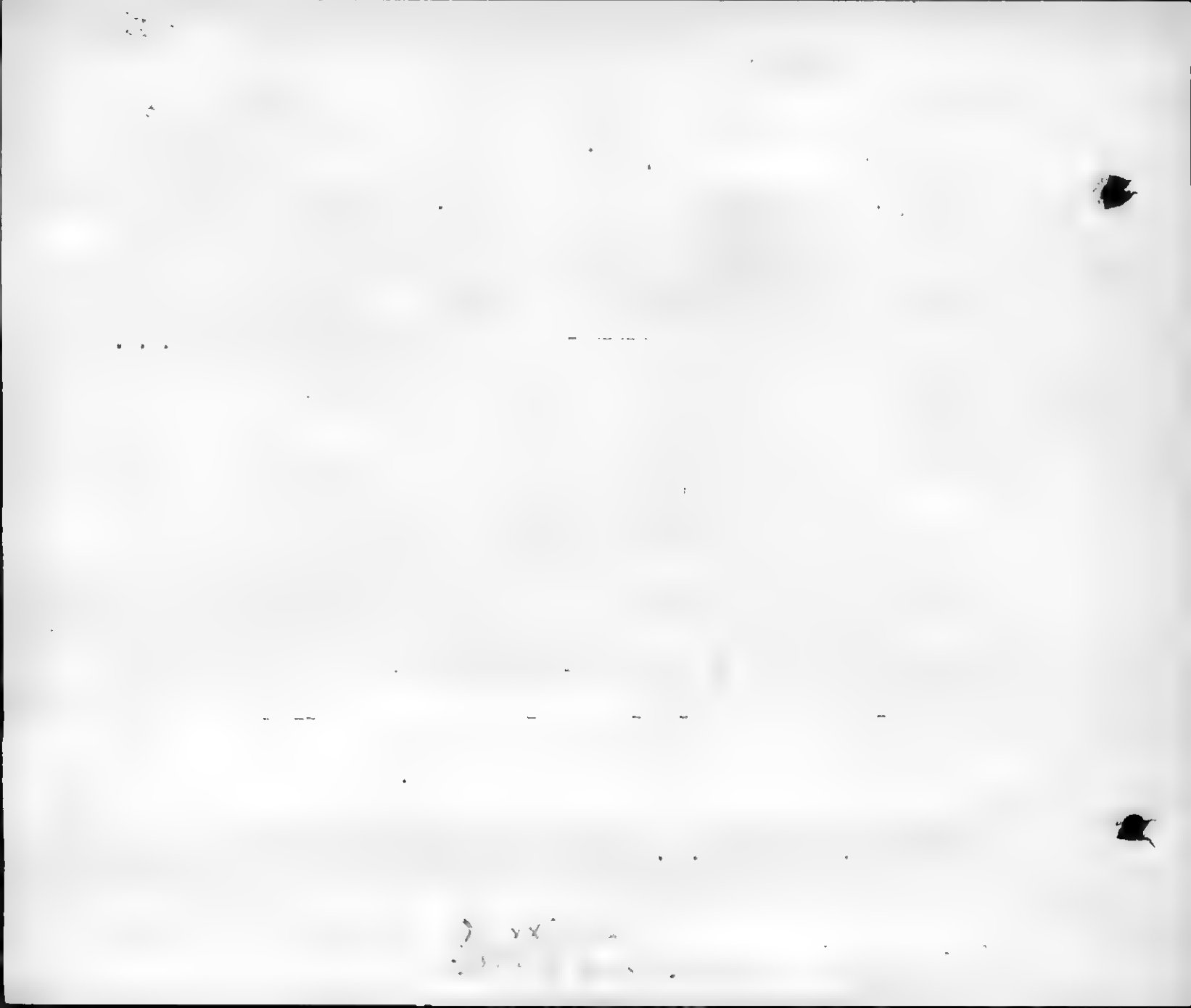
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13401

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13351

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 8 yrs. 3mo. 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 VC-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 703 N. Mount Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hawkins, Middle Last Addie				4. DATE OF DEATH Month 12 Day 21 Year 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1883?	
9. AGE (In years last birthday) 77? yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Dollie Jones Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) Arteriosclerotic Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month. Day. Year Hour o m. ----- 19 p. m. -----				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) (County) (State) -----							
21. I certify that (I) (this hospital) attended the deceased from 9/4 to 12/21 , 19 60 that (I) (we) last saw the deceased alive on 12/21 , 19 60 , and that death occurred at 10:15 p. m. from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 12/22/60			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 12-24-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				25a. REC'D BY REGISTRAR DEC 27 '60		25b. REGISTRAR'S SIGNATURE [Signature]	



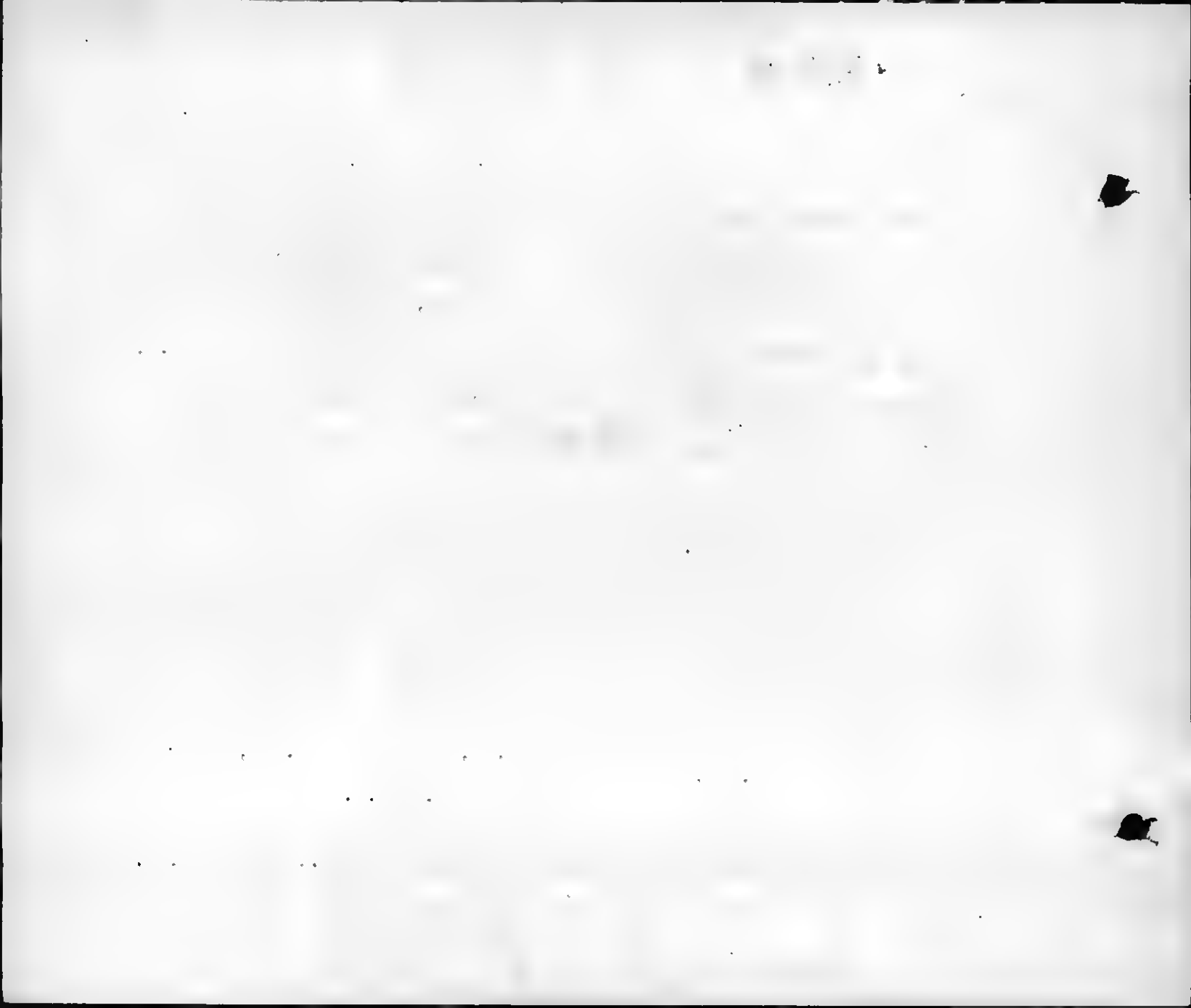
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13352

13350

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. STREET ADDRESS 1 Cypress Creek Road			
3 NAME OF DECEASED (Type or print) First Howard Middle M Last HAYS				4. DATE OF DEATH Month December Day 13 Year 19 60			
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1909		9. AGE (In years last birthday) 51 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Oscar G. Hays				14. MOTHER'S MAIDEN NAME Lucinda			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO 215 248609		17. INFORMANT Family Address Chesapeake	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal broncho pneumonia DUE TO Aspirated esophageal varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver DUE TO (c) 5-10 years.							INTERVAL BETWEEN ONSET AND DEATH 2 days 1 week.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ALCOHOLISM							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec. 6, 1960 to Dec. 13, 1960 , that (I) (the hospital) saw the deceased alive on Dec. 13, 1960 , and that death occurred at 12:40 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Gerald Church				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/13/60	
22c. PHYSICIAN'S NAME (Type) Gerald Church				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 12-16-60		23c. NAME OF CEMETERY OR CREMATORY St. Ann Haven Cem		23d. LOCATION (City, town, or county) (State) St. Ann, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert S. Baranco				ADDRESS Severna Park		25a. REC'D BY REGISTRAR DATE DEC 19 60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



13378

CERTIFICATE OF DEATH

13353

Reg. Dist. No.

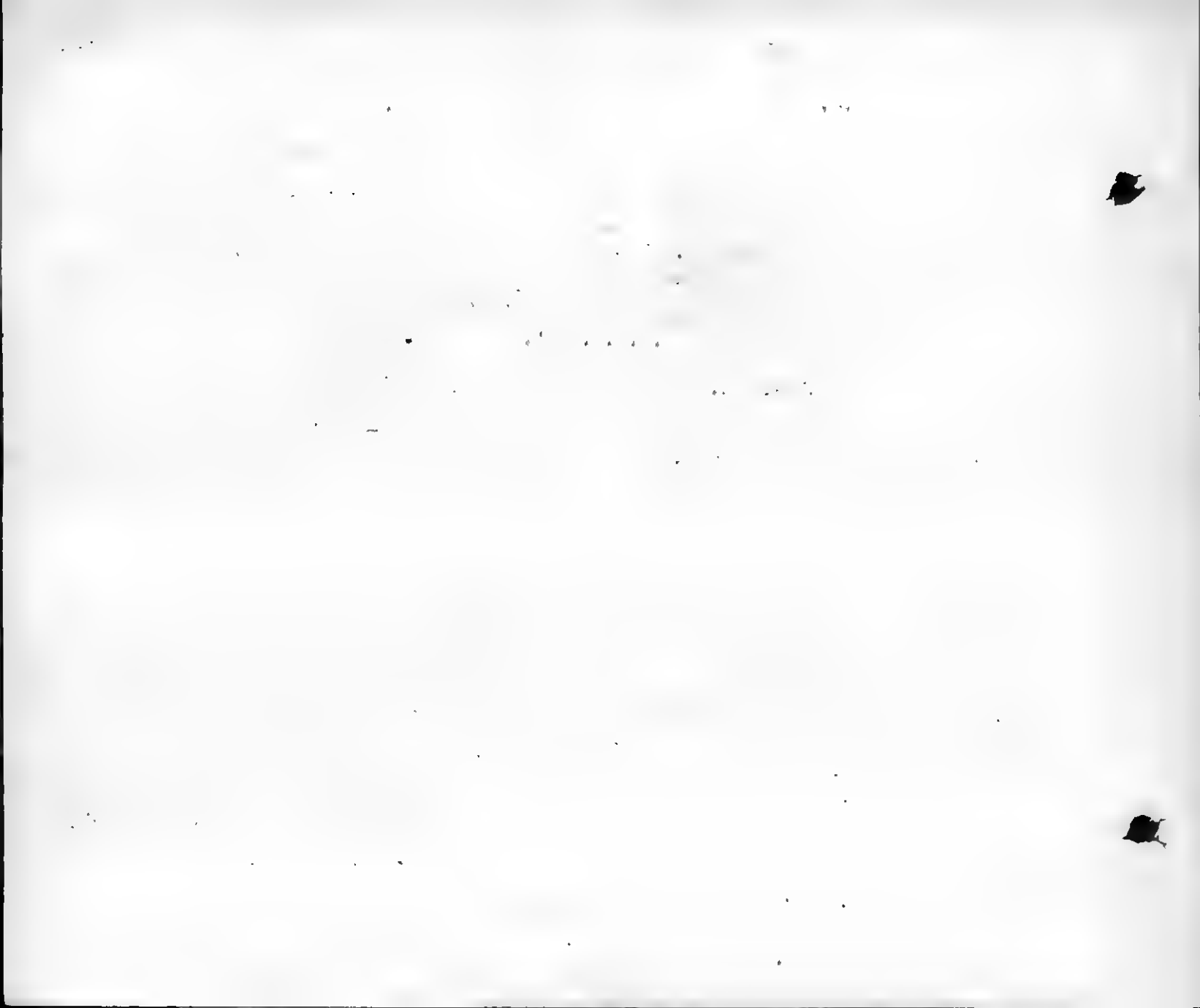
1 PLACE OF DEATH a. COUNTY A.A. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY 9	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Riviera Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 Hilltop Road		d STREET ADDRESS 209 Hilltop Road	
3 NAME OF DECEASED (Type or print) First EDWARD W. Middle HEALY Last		4. DATE OF DEATH 12/20/60 Month Day Year 19	
5 SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/96
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholsterer		10b. KIND OF BUSINESS OR INDUSTRY U.S.C.G. Ret.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward M.		14. MOTHER'S MAIDEN NAME Catherine Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1	
INFORMANT Family - Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 183X IMMEDIATE CAUSE (a) Carcinoma Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 19 60 , to Dec. 19 19 60 , that I last saw the deceased alive on Dec. 19 19 60 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. Brady Smith M.D. 8471 Ft. Smallwood Rd 12/20/60 ACTUAL SIGNATURE J. BRADY SMITH Paradise, Md PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 12/23/60	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore	
23 FUNERAL DIRECTOR'S SIGNATURE McCully - 130 E. Fort Avenue		24a. REC'D BY REGISTRAR DATE DEC 23 '60	
24b. REGISTRAR'S SIGNATURE C. S. H. H. H.			

1

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58



13402

CERTIFICATE OF DEATH

Reg. Dist. No.

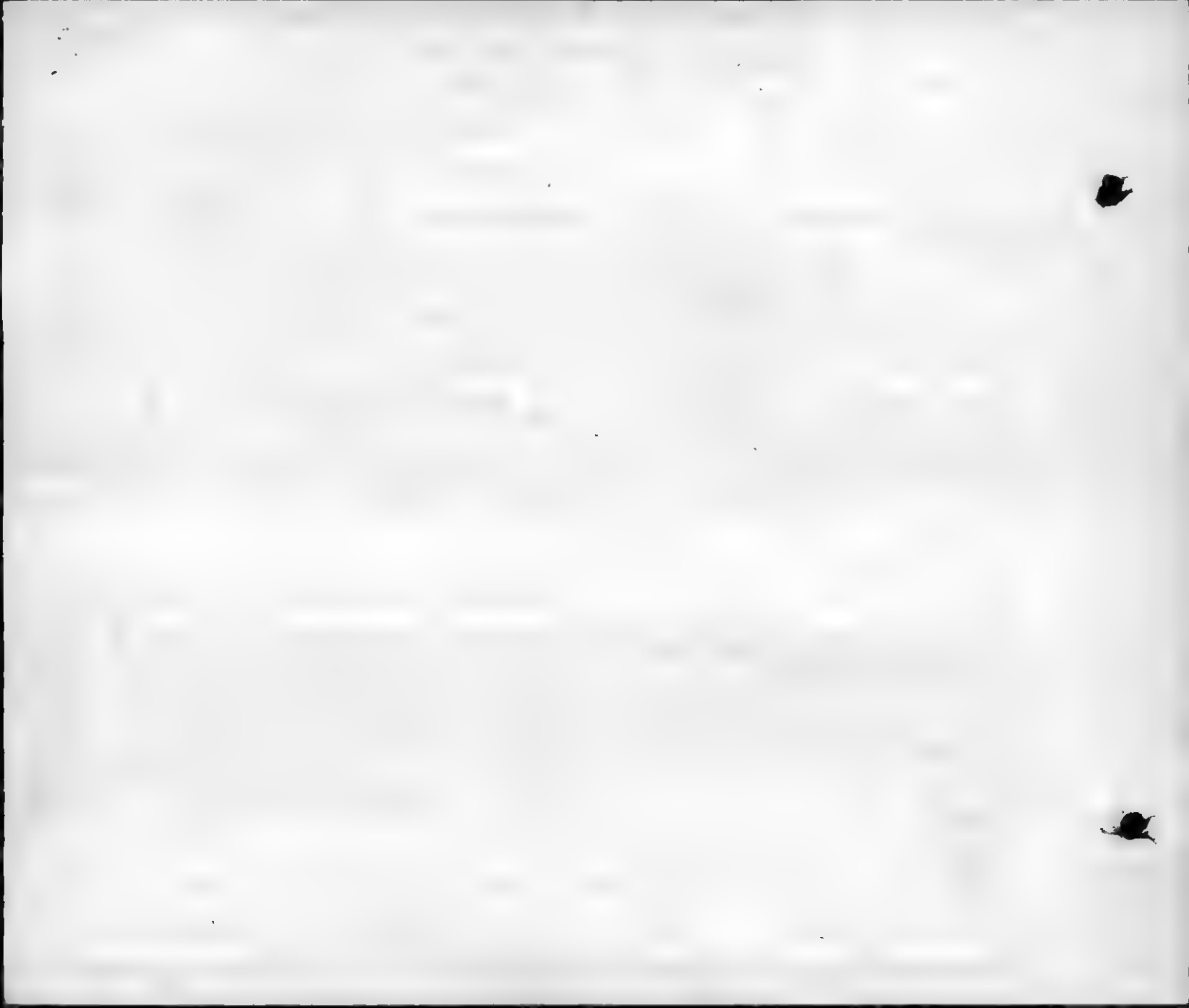
13354

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1007 Balto.-Annap. Blvd., N.E.</u>		d. STREET ADDRESS <u>1007 Balto.-Annap. Blvd., N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN WADE HENKEL</u>		4. DATE OF DEATH <u>Dec 1 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-1888</u> 72 yrs
9. AGE (In years last birthday) <u>72</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel G. Henkel</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-05-5133</u>	
17. INFORMANT <u>Mrs. Anna L. Henkel</u>		Address <u>Same As F2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC Heart Disease and Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1959</u> to <u>Dec 1 1960</u> , that I last saw the deceased alive on <u>Nov 30 1960</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Taler</u>		ADDRESS (Street, city or town, state) <u>102 B & A Blvd. N.E.</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH TALER</u>		DATE SIGNED <u>12-1-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5th Dec. 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemo</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.V. Dineen</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



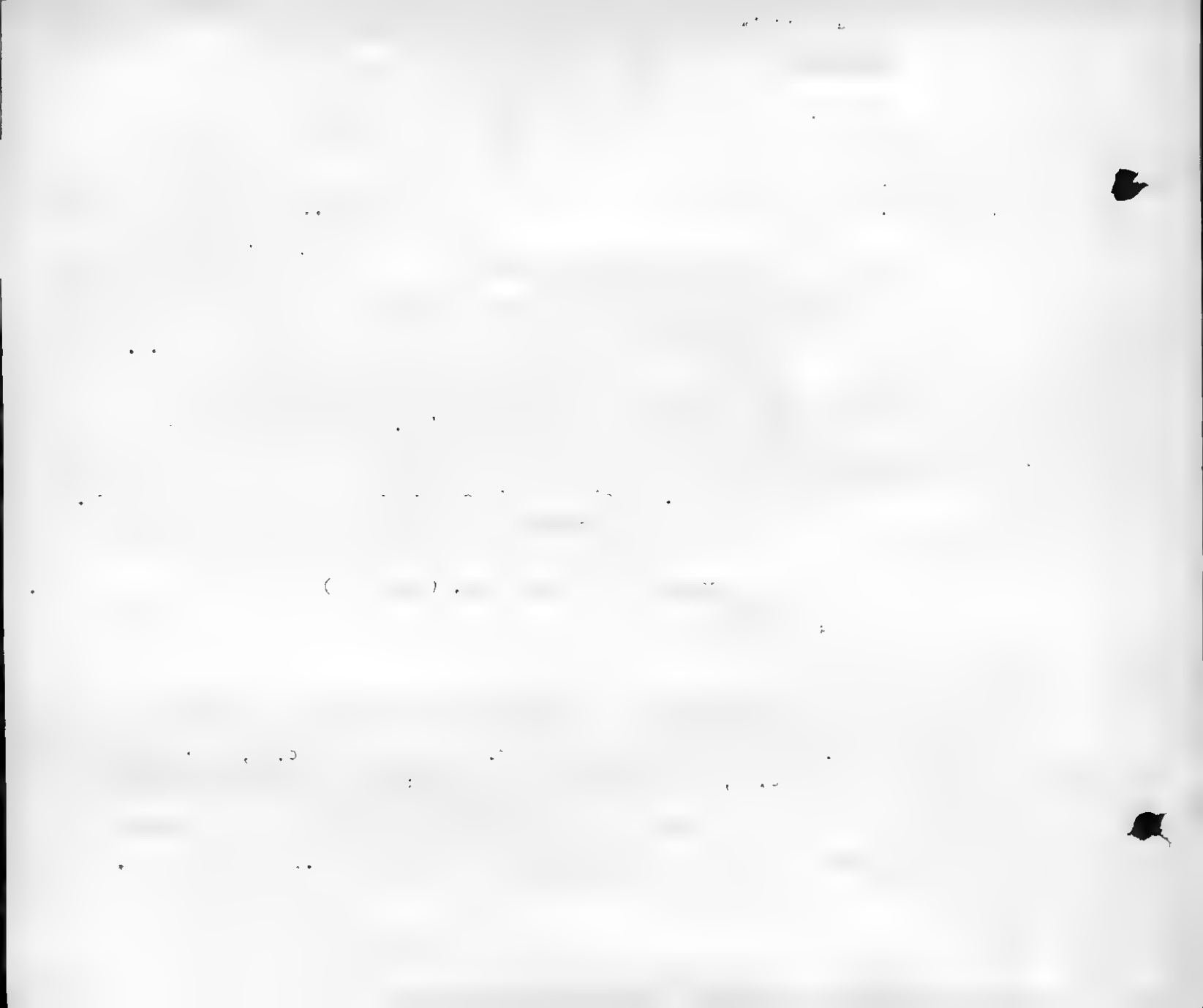
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13351

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13355

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Dead on arrival) Anne Arundel General Hospital		d. STREET ADDRESS 207 Lockwood St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Madeline Middle GROLZ Last HEROLD		4. DATE OF DEATH Month December Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 9, 1896
9. AGE (In years last birthday) 64 yrs		10. IF UNDER 1 YEAR Months 64 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CHARLES GROLZ		14. MOTHER'S MAIDEN NAME Emily Christy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO —	
17. INFORMANT ANTHONY HEROLD		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gen. carcinomatosis c cerebral metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of breast rt. (resected) DUE TO (c) diabetes mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes mellitus			
19. INTERVAL BETWEEN ONSET AND DEATH 3 hrs.			
20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from Apr. 59 to Dec. 4, 1960 , that (I) (x) last saw the deceased alive on Dec. 3, 1960 , and that death occurred at 9:40 AM from the causes and on the date stated above			
22a. SIGNATURE Samuel Borssuck		22b. DATE SIGNED 12/6/60	
22c. PHYSICIAN'S NAME (Type) Samuel Borssuck		22d. ADDRESS Amos Garrett Blvd., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 12-6-60	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Lytle & Sons Annapolis, Md.		25a. REC'D BY REGISTRAR DEC 8 '60	
		25b. REGISTRAR'S SIGNATURE C. J. S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13356

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY X			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) James E. Holland				4. DATE OF DEATH Month 12 Day 31 Year 1960			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2, 1931	9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 850X IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell overboard from own oyster boat					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12.31 19 60		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay		20f. (City or town) Annapolis (County) Anne (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE [Signature]		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/31/60	
EXAMINER'S NAME (Type) E. L. Holland		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
[Signature]		[Address]		DATE 9 '61		[Signature]	

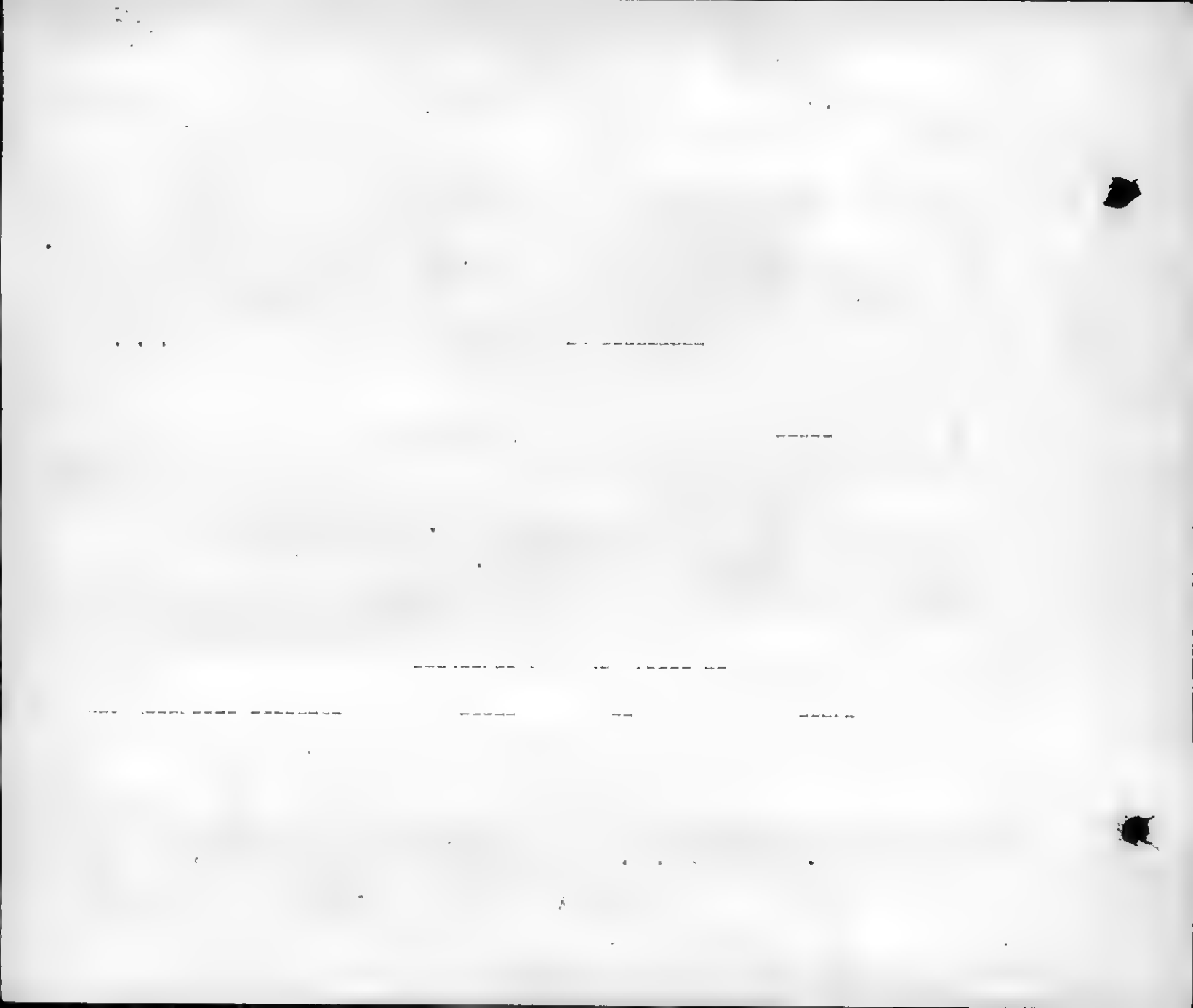
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13404

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13357

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Montgomery ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 31 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle O Last Hopkins				4. DATE OF DEATH Month 12 Day 19 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1886	
9. AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lewis Hopkins				14. MOTHER'S MAIDEN NAME Emma Berry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO				16. SOCIAL SECURITY NO Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Failure 442X DUE TO Chronic Brain Syndrome ass. with Hypertensive - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular Disease. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month. Day Year Hour o m p. m. ----- 19 -----				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) (County) (State) -----							
21. I certify that (I) (this hospital) attended the deceased from 12/19/60 to 12/19/60 , that (I) (we) last saw the deceased alive on 12/19/60 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>L. Benedict, M.D.</i>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		12/19/60 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) -----		23b. DATE THEREOF 12-29-60		23c. NAME OF CEMETERY OR CREMATORY 2407 Md		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr.</i>				ADDRESS -----		25a. REC'D BY REGISTRAR DATE DEC 30 60	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

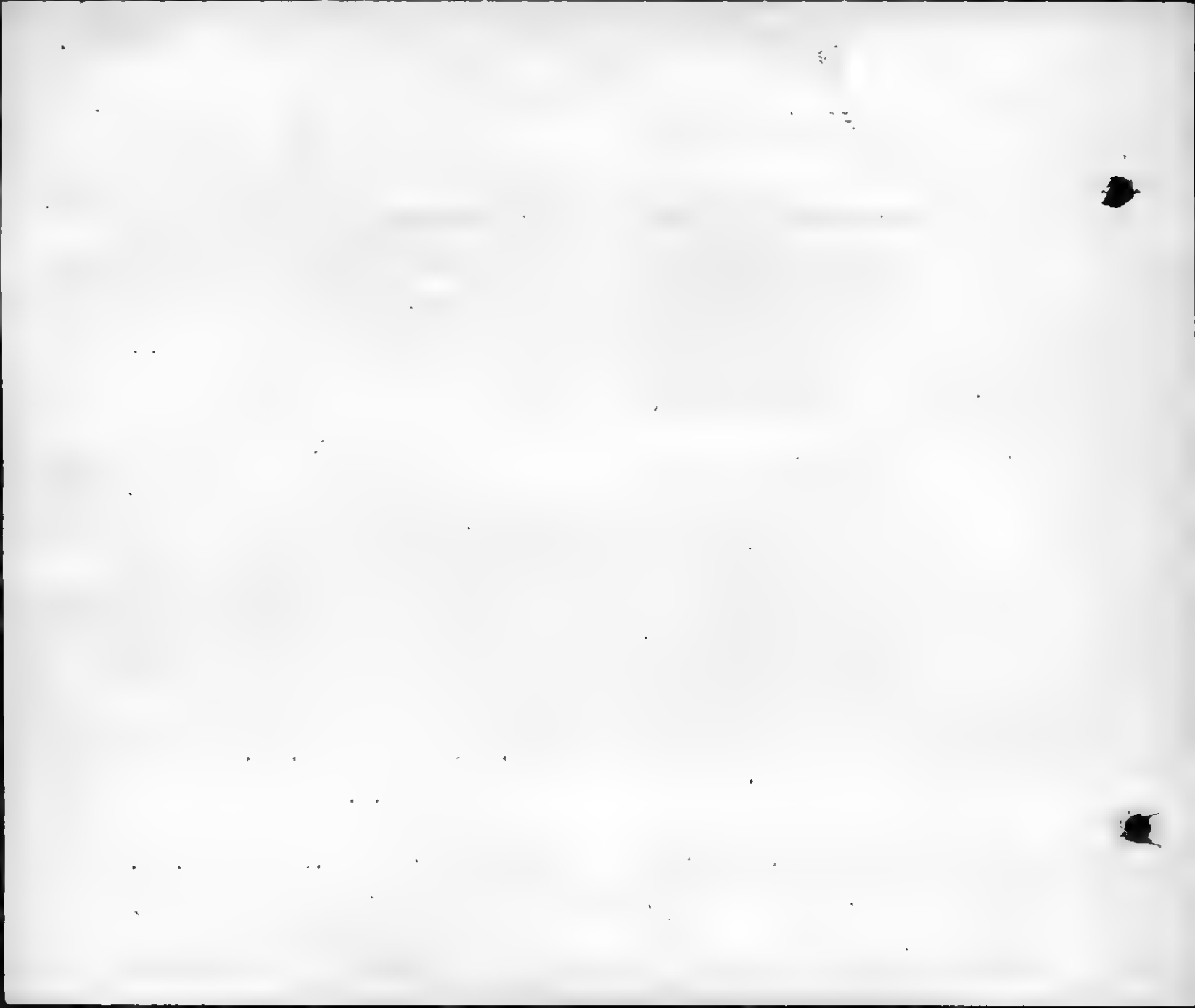
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13352

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13358

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1089 MAIN ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS ANNAPOLIS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) SARAH First		JANE Middle		HOWERSHELT Last		4. DATE OF DEATH Month December Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 15, 1875		9. AGE (In years lost birthday) 85 yrs	IF UNDER 1 YEAR Months 85 Days 85 Hours 85 Min 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME SAMUAL MONTGOMERY				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT Address MRS THOMAS H. GROSE #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive jaundice 155-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of cystic duct DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 10 da 1 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease with congestive failure							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour — a. m. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from Dec. 14, 1960 to Dec. 22, 1960 that (I) (saw) last saw the deceased alive on Dec. 22, 1960 , and that death occurred at 4:30 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE Richard N. Peeler M.D.				ATTENDING PHYS 4:30 A.M. MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/22/60	
22c. PHYSICIAN'S NAME (Type) Richard N. Peeler				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-24-1960		23c. NAME OF CEMETERY OR CREMATORY HILLCREST MEM.		23d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN M. TAYLOR - SOUS ADDRESS ANNAPOLIS MD.				25a. REC'D BY REGISTRAR DEC 27 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Howard	

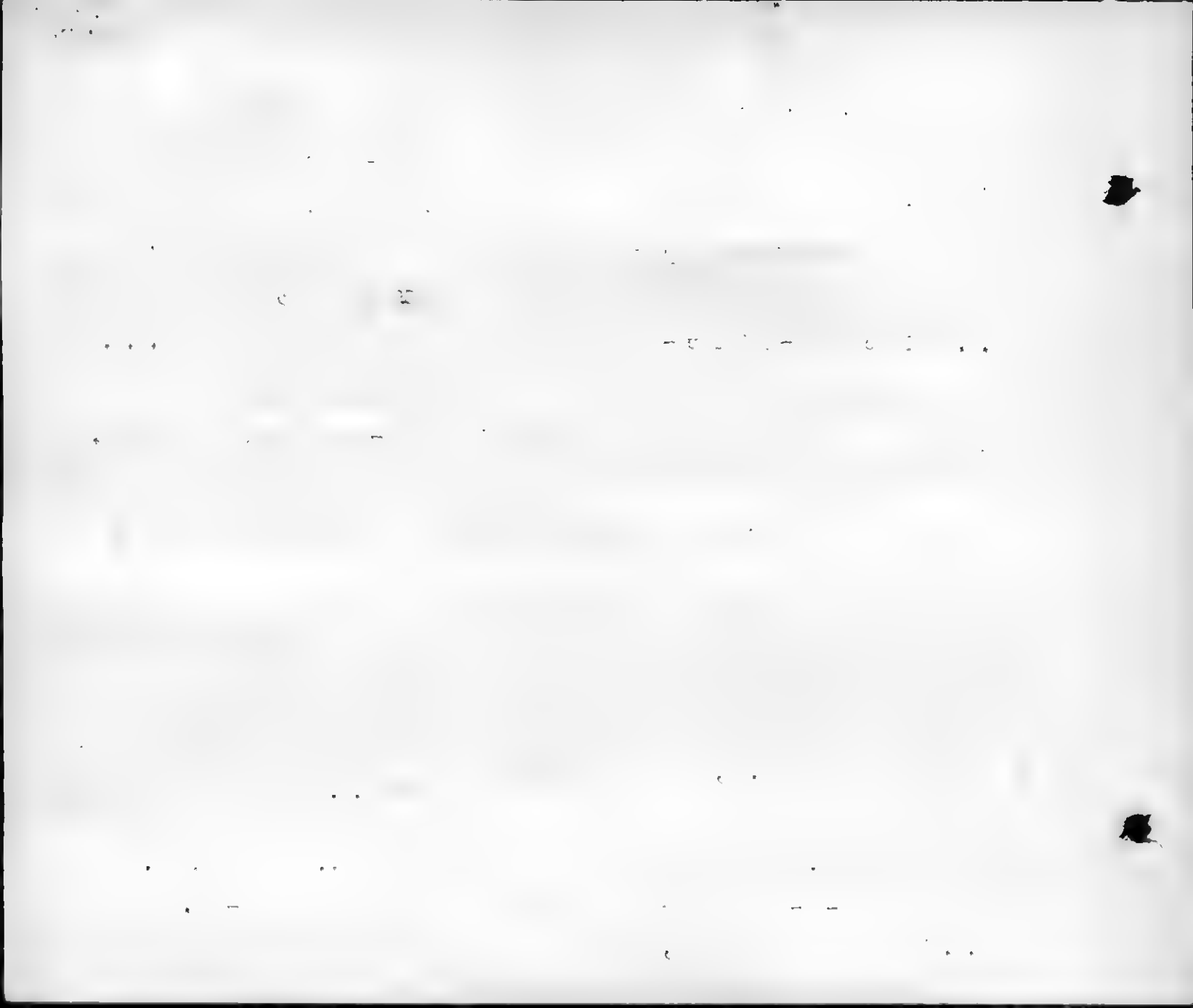


VR A15 (4)
ISM #/S9

13354

13359

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution Residence address should be addressed) a. STATE		b. COUNTY	
Anne Arundel		Annapolis		3 days		Maryland		Anne Arundel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Anne Arundel General Hospital				1 Rt-1, Box-410,					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
* Rayfield Rayfield						JACKSON		December 7 1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS
Male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	May 16, 1885		75		Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
U.S. Naval Academy - Laborer - retired						Maryland			U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Andrew Jackson				Louise Kelly					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		None		Irene Williamson-Box 410 Severna Park Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrolytic interference</u> 561.5 DUE TO <u>Byrical Cytidine base & benzene</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>streptococcal pneumonia</u> DUE TO (c) <u>streptococcal pneumonia</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
19		While <input type="checkbox"/> Not while <input type="checkbox"/>							
21. I certify that (I) (Name of physician) attended the deceased from 8:20 A.M. to 12-7-60, that (I) (Name of physician) saw the deceased alive on Dec. 7, 1960, and that death occurred at M. from the causes and on the date stated above.									
22a. SIGNATURE				22b. DATE				22c. PHYSICIAN'S NAME (Type)	
Aris T. Allen				8:20 A.M.				SIGNED	
MD				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
Aris T. Allen				62 Cathedral St., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
Burial		12-11-60		Carpenters Hill		Severna Park- Md.			
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
C.E. Hicks III				DEC 14 '60		Arthur S. Hanks			
ADDRESS				25c. REGISTRAR'S SIGNATURE					
Annapolis, Maryland									



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13355 CERTIFICATE OF DEATH 13360

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> d. STREET ADDRESS <u>11 Maryland Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH, Annapolis, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Horace Homer Jalbert</u>				4. DATE OF DEATH Month Day Year <u>December 15th 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/19/1891</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		IF UNDER 24 HRS: Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN - Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Joseph J. Jalbert</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Pinault</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WWI and II</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Wife - 11 Maryland Avenue, Annapolis, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO (b) <u>Gangrene left thigh with infection</u> DUE TO (c) <u>Generalized Arteriosclerosis Obliterans</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 weeks</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>11/7</u> , 19 <u>60</u> , to <u>12/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>60</u> , and that death occurred at <u>11:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>R. G. Williams</u>				M.D. <u>USNH, ANNAPOLIS, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>R. G. WILLIAMS, JR., CDR MC USN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec-19-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor</u>				24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13356
CERTIFICATE OF DEATH

13361

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>17</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 Pleasant Street</u>				d. STREET ADDRESS <u>74 Pleasant St.</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>Johnson</u> Middle <u>Johnson</u> Last				4. DATE OF DEATH <u>12</u> Month <u>31</u> Day <u>1960</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-25-1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs		10. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Green</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>Naomi Kirby 74 Pleasant St.</u>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Enteric salmonella typhosa</u> 4437- DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac valve disease</u> DUE TO (c) <u>5 months</u> INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> 19 <u>60</u> to <u>11/31</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11/31</u> 19 <u>60</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>R. Richardson</u>				22b. DATE SIGNED <u>1/4/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. Richardson M.D.</u>				22d. ADDRESS <u>110 - clay street Annapolis Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-5-1961</u>		<u>Brewer Hill</u>		<u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #</u>				25a. REC'D BY REGISTRAR <u>1/4/61</u>			
ADDRESS <u>Annapolis Md.</u>				25b. REGISTRAR'S SIGNATURE <u>C. Hunt & Thrall</u>			

TO HOSPITAL
may be
TO F.

VS A15 1-
15M 10/2

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours
by the hospital or attending physician.
TOR: After this certificate has been signed by the attending physician and completely filled in by
be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 &

13357

CERTIFICATE OF DEATH

13362

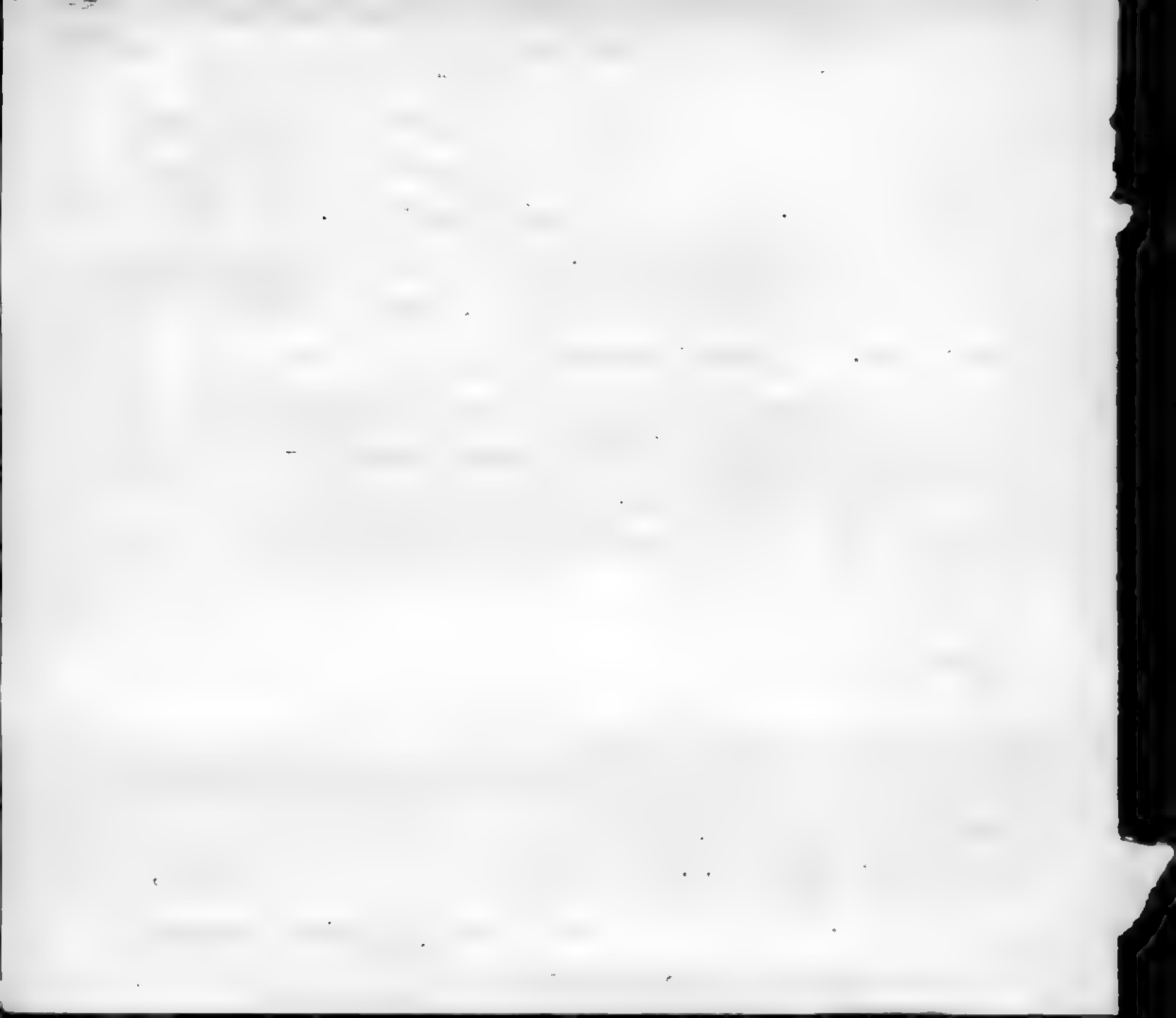
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 138 Lafayette Ave.		d. STREET ADDRESS 138 Lafayette Ave.	
3. NAME OF DECEASED (Type or print) First HARRY Middle A Last KLAWANS		4. DATE OF DEATH Month DECEMBER Day 6 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Prop.		10b. KIND OF BUSINESS OR INDUSTRY Retail Dress Shop	
13. FATHER'S NAME David Klawansky		14. MOTHER'S MAIDEN NAME Lena (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 218 32 2074	
17. INFORMANT Mrs Fannie Klawans- Wife- Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 42-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes M. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes M.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 Wks.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-6-60 , 19 60 to 12-7-60 , 19 60 that I last saw the deceased alive on 12-7-60 , and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Maryland DATE SIGNED 12-7-60			
ACTUAL SIGNATURE Frank Shipley M.D.		DATE SIGNED 12-7-60	
PHYSICIAN'S NAME (Type) Frank Shipley M.D.		Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping		24a. REC'D BY REGISTRAR DEC 9 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Farnham		ADDRESS Annapolis, Maryland	

page 3 should be the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

GENERAL D



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13405

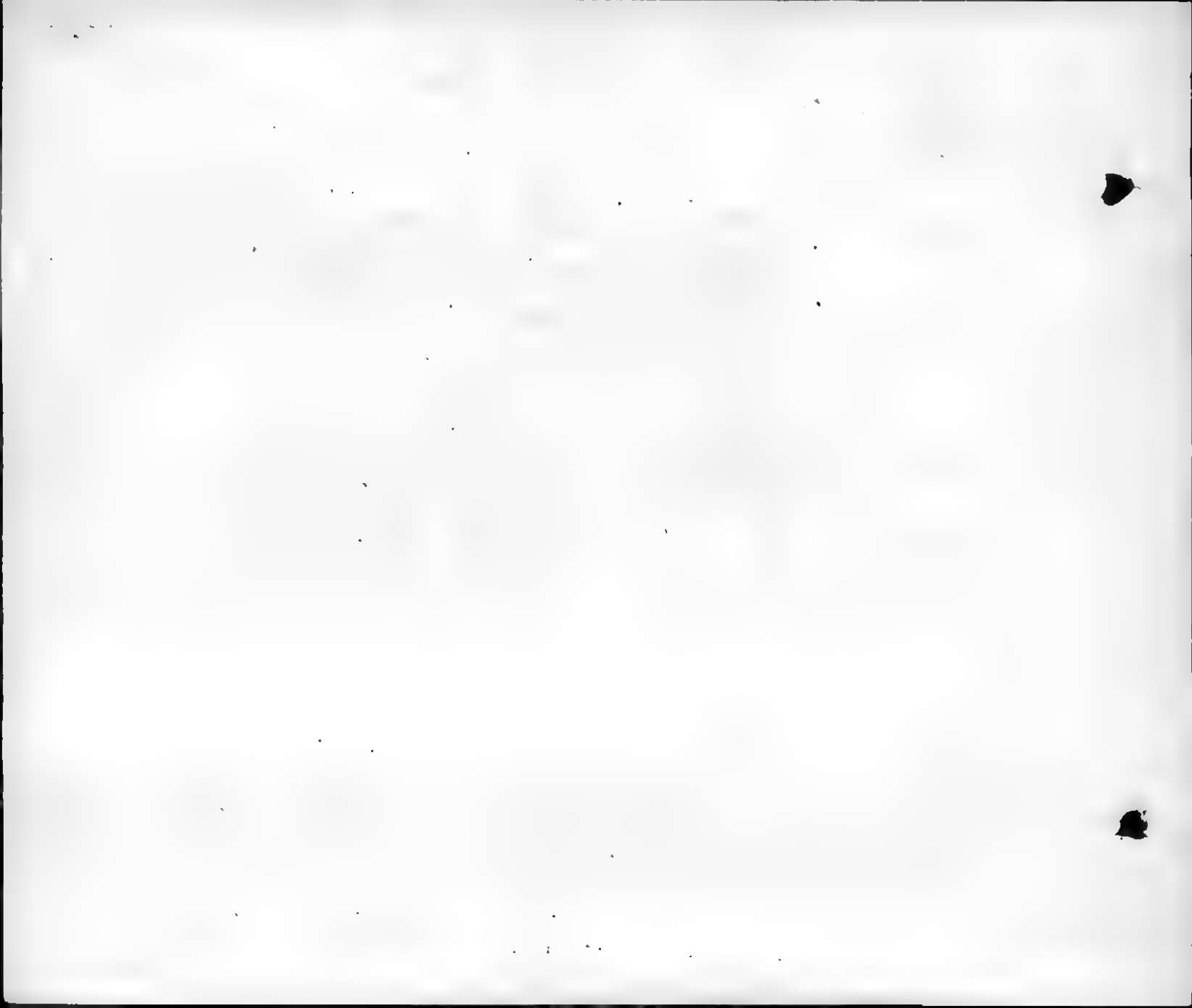
CERTIFICATE OF DEATH

13363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN PK</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 W. 324 AVE.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> d. STREET ADDRESS <u>5 W. 324 AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>KREIG</u> Last <u>KREIG</u>				4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1960</u>															
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-24-1879</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Genl. Eng.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>14000</u>				11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>UNK</u>						14. MOTHER'S MAIDEN NAME <u>UNK</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service) <u>NO</u>						16. SOCIAL SECURITY NO. <u>FAMILY</u>						INFORMANT <u>Family</u> Address <u>Same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung, metastatic</u> DUE TO <u>Carcinoma of Pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/16</u> , 19 <u>50</u> , to <u>12/27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>12/27</u> , 19 <u>60</u> , and that death occurred at <u>10:00</u> A.M. from the causes and on the date stated above.																			
ACTUAL SIGNATURE <u>Benjamin Berdann</u> M.D.				ADDRESS (Street, city or town, state) <u>5010 1st Avenue, Brooklyn, N.Y.</u>				DATE SIGNED <u>12/28/60</u>											
PHYSICIAN'S NAME (Type) <u>BENJAMIN BERDANN</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>22</u>				22b. DATE THEREOF <u>12-30-60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Brooklyn MD.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Hse.</u> ADDRESS <u>1302 E. Fort Ave.</u>								24a. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Charles E. H.</u>							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13364

Reg. Dist. No.

13406

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Md. c. COUNTY A.A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 9 - P.O. ANNE ARUNDEL GEN.				d. STREET ADDRESS 1 Rt. 9		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle CHARLES Last KRISS				4. DATE OF DEATH Month Dec. Day 5 Year 19 60			
5. SEX M	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25 1890		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Printer		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Kriss				14. MOTHER'S MAIDEN NAME Beatrice ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac disease 434-4 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. Linhardt M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. Linhardt				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/60		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie Md.	
23. FUNERAL DIRECTOR'S SIGNATURE SEVERNA PARK FUNERAL HOME				24a. REC'D BY REGISTRAR DEC 8 '60		24b. REGISTRAR'S SIGNATURE Gordon S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

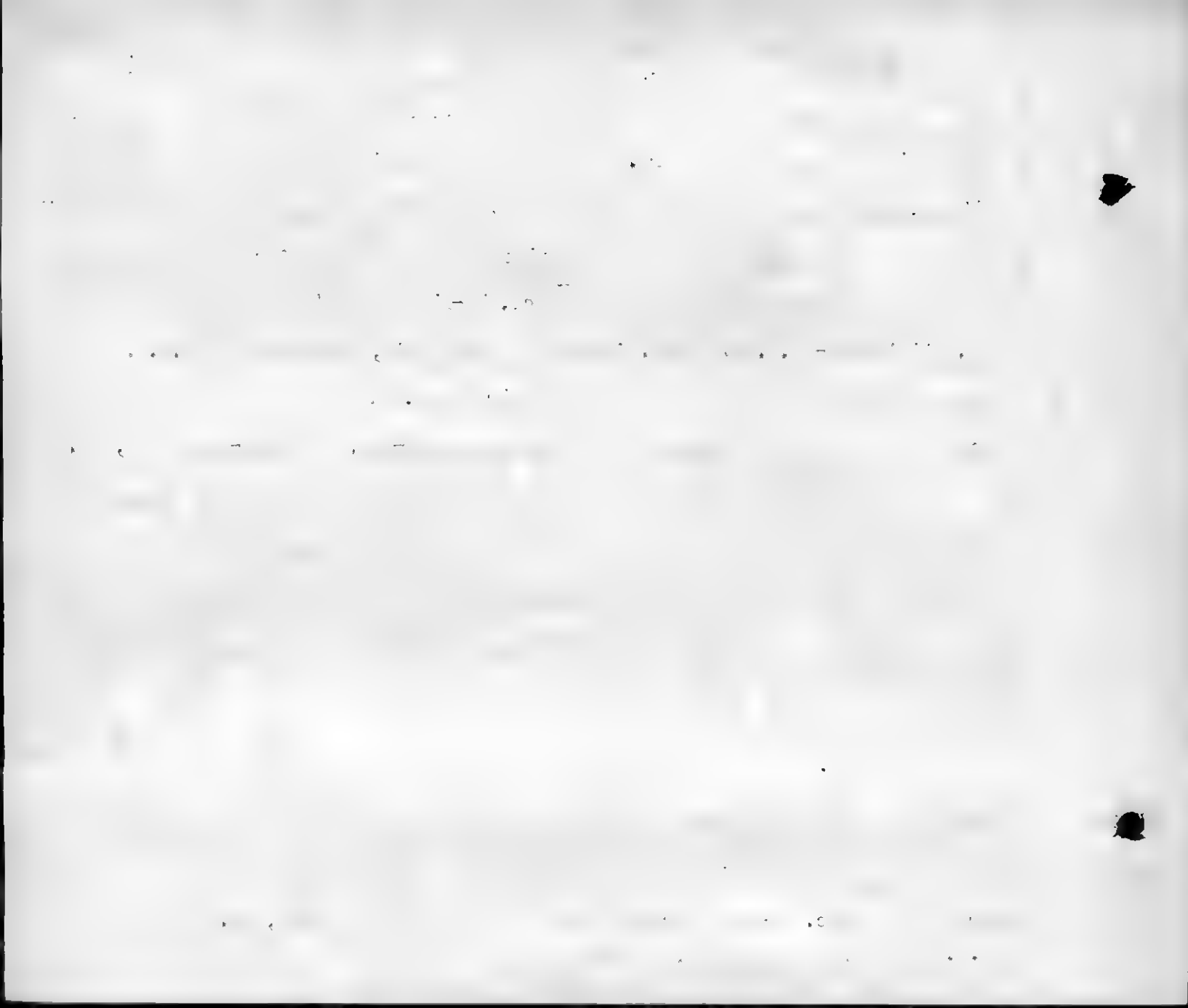
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN Hrs. Hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 927 Spa Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 817 Spa Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Kyler Last Kyler				4. DATE OF DEATH Month December Day 7 Year 19 60			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15-1914		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Utilities - U.S. Naval Exp. Station		10b. KIND OF BUSINESS OR INDUSTRY Annopolis, Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Kyler				14. MOTHER'S MAIDEN NAME Airy Crompton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Florence Green- 817 Spa Road-Annapolis, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer 424.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 12.7-60	
EXAMINER'S NAME (Type) E. Linhardt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10-60		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE DEC 14 '60	
				24b. REGISTRAR'S SIGNATURE Robert S. Thomas			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13407

13366

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MILLERSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 26 - 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Knollwood Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last STELLA (Estelle) LADNER				4. DATE OF DEATH Month Day Year Dec. 24 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 10-1886	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Champaign, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.B.	
13. FATHER'S NAME Samuel Zingling				14. MOTHER'S MAIDEN NAME Sadie Reinhardt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-05-42220		17. INFORMANT Address Robt. L. Ladner (Same)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BACILLARY PNEUMONIA. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRO VASCULAR DISEASE DUE TO (c) 4 days. 4 months						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 10:20 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/17 1960 , to 12/24 1960 ; that (I) (we) last saw the deceased alive on 12/20 1960 , and that death occurred at PM , from the causes and on the date stated above.							
22a. SIGNATURE Gerard Church				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 12/25/60	
22c. PHYSICIAN'S NAME (Type) GERARD CHURCH				22d. ADDRESS 121 CATHOLIC ST. ST. LOUIS			
23a. BURIAL, CREMATION, REMOVAL. (Specify) BURIAL		23b. DATE THEREOF Dec. 28-1960		23c. NAME OF CEMETERY OR CREMATORY Glenn Haven Cem.		23d. LOCATION (City, town, or county) (State) Glenn Burnie Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ANGUARD EVANS & SON				25a. REC'D BY REGISTRAR 4005 CHARLES ST. BALTO 30 MD		25b. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

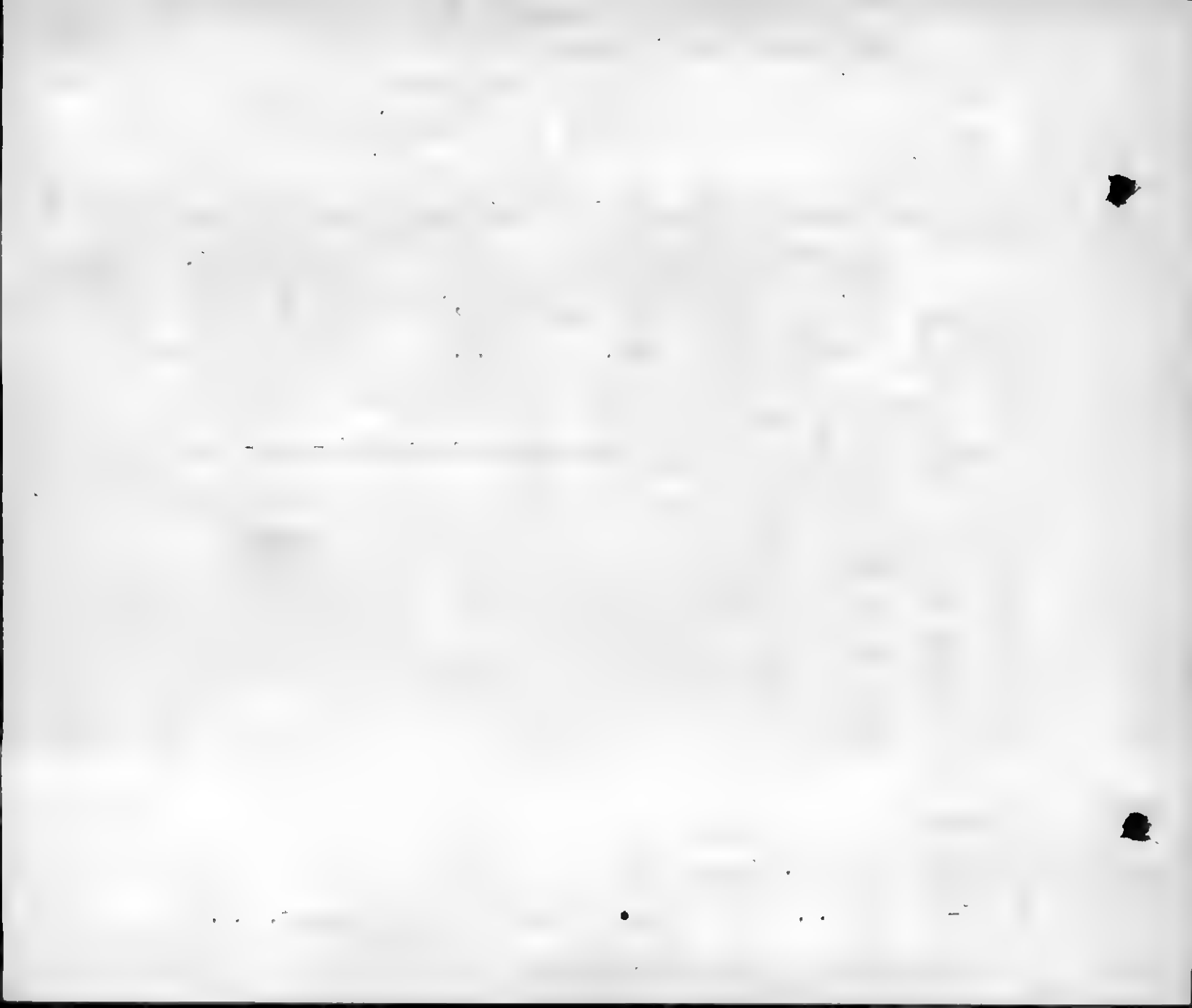
13359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN lb 			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Anne Arundel General Hospital				d. STREET ADDRESS 53 1/2 West Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DORMAN H LEWIS				4. DATE OF DEATH Month DECEMBER Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 15, 1935	
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months 25 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Operator				10b. KIND OF BUSINESS OR INDUSTRY Road Const.		11. BIRTHPLACE (State or foreign country) N.C.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert Hayes Lewis				14. MOTHER'S MAIDEN NAME Maudy Walston			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212 50 3576		17. INFORMANT Address Mrs Laverne Cox Lewis- Wife- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____						INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) Auto accident Rt 750			
20c. TIME OF INJURY Month, Day, Year 12-3 1960 Hour 5 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) ABer (County) MS (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <i>Elmer G. Linhardt</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/3/60	
EXAMINER'S NAME (Type) Elmer G. Linhardt				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF Dec. 5, 1960		22c. NAME OF CEMETERY OR CREMATORY Southport Cemetery		22d. LOCATION (City, town, or county) Southport, N.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DEC 7 '60	
				24b. REGISTRAR'S SIGNATURE <i>Charles E. Harris</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



13379

CERTIFICATE OF DEATH

13368

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>		c. LENGTH OF STAY IN 1b <u>30 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8442 GARDEN ROAD</u>		e. STREET ADDRESS <u>8442 GARDEN ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>ANN</u> Last <u>MARTIN</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 3, 1918</u>
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO., MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MILLARD F. DOWNEY</u>	
14. MOTHER'S MAIDEN NAME <u>MARY A. GARDINER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>219-16-4803</u>		17. INFORMANT Address <u>Mrs. JUDY HENINGSEN SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA BREAST WITH METASTASES</u> <u>110X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ cause (c), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>FEB.</u> 19 <u>44</u> , to <u>DEC. 29, 1960</u> , that I last saw the deceased alive on <u>DEC. 28, 1960</u> , and that death occurred at <u>9:05 AM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>8442 FT. SMALLWOOD ROAD</u>		DATE SIGNED <u>12/29/60</u>	
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.		PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 3, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		22d. LOCATION (City, town, or county) (State) <u>FAIRFAX COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Cole</u> ADDRESS <u>1913 W. Belts St.</u>		24a. REC'D BY REGISTRAR DATE <u>AN 3 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Orlando S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



13408

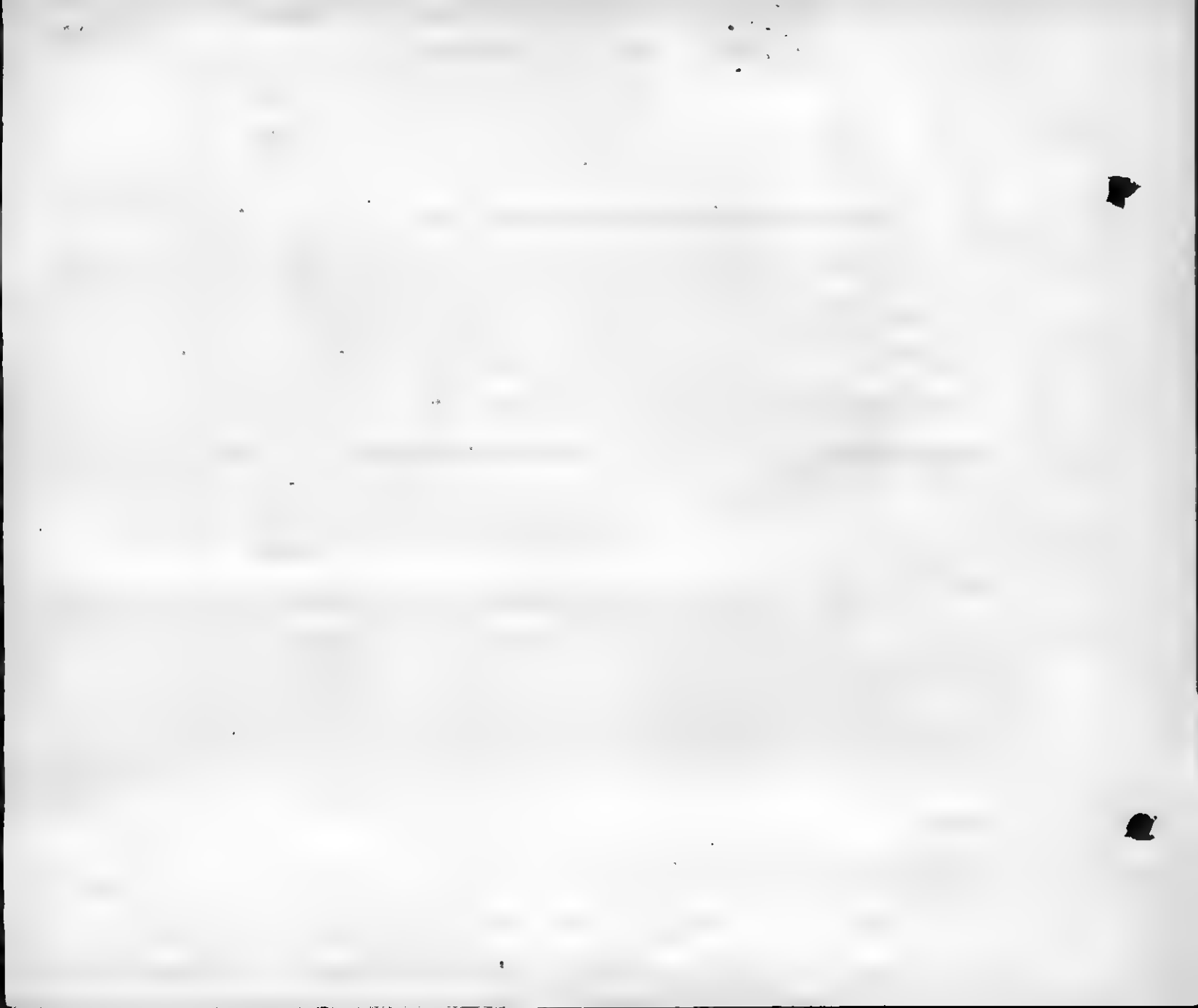
CERTIFICATE OF DEATH

13369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundle</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harmons (Glen) Burnie</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		
c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			d. STREET ADDRESS <u>Box #440 Harmons Rd.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box #440 Hanover Md.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theodore Matthews</u>			4. DATE OF DEATH Month Day Year <u>Dec 22, 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1907</u>		9. AGE (In years last birthday) yrs <u>53</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (State or foreign country) <u>Harmons Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Nicholas Matthews</u>			14. MOTHER'S MAIDEN NAME <u>Rossie Oliver</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>717-07-6750</u>	17. INFORMANT <u>Helen L. Matthews Box #440 Harmons Rd.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> DUE TO <u>Carcinoma of Stomach</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 mos.</u> <u>5 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 30, 1960</u> to <u>December 22, 1960</u> , that I last saw the deceased alive on <u>Dec. 22, 1960</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.			ADDRESS (Street, city or town, state) DATE SIGNED <u>Savage, Md. 12/24/60</u>		
PHYSICIAN'S NAME (Type) <u>Frank E. Shipley, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/26/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sts Rest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Harmons Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Nutter-3035 W. North Ave.</u>			24a. REC'D BY REGISTRAR DATE <u>DEC 27 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Carl E. Stuedgen</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 48 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13409

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13370

1. PLACE OF DEATH a. COUNTY <u>AA CO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville.</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville - State - Hosp.</u>				d. STREET ADDRESS <u>Baker - St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert (Rothert) McCracken</u>				4. DATE OF DEATH Month Day Year <u>12 25 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-1900</u>		9. AGE (In years last birthday) <u>60 yrs.</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Louis McCracken</u>				14. MOTHER'S MAIDEN NAME <u>Mary ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-10-0640</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural-Hemorrhage</u> DUE TO <u>Fracture - Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated w. Chronic alcoholism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <u>before 12/16/ 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>unknown</u>		20f. (City or town) (County) (State) <u>Baltimore Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>F. L. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/28/60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Int. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Halstead</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



13360

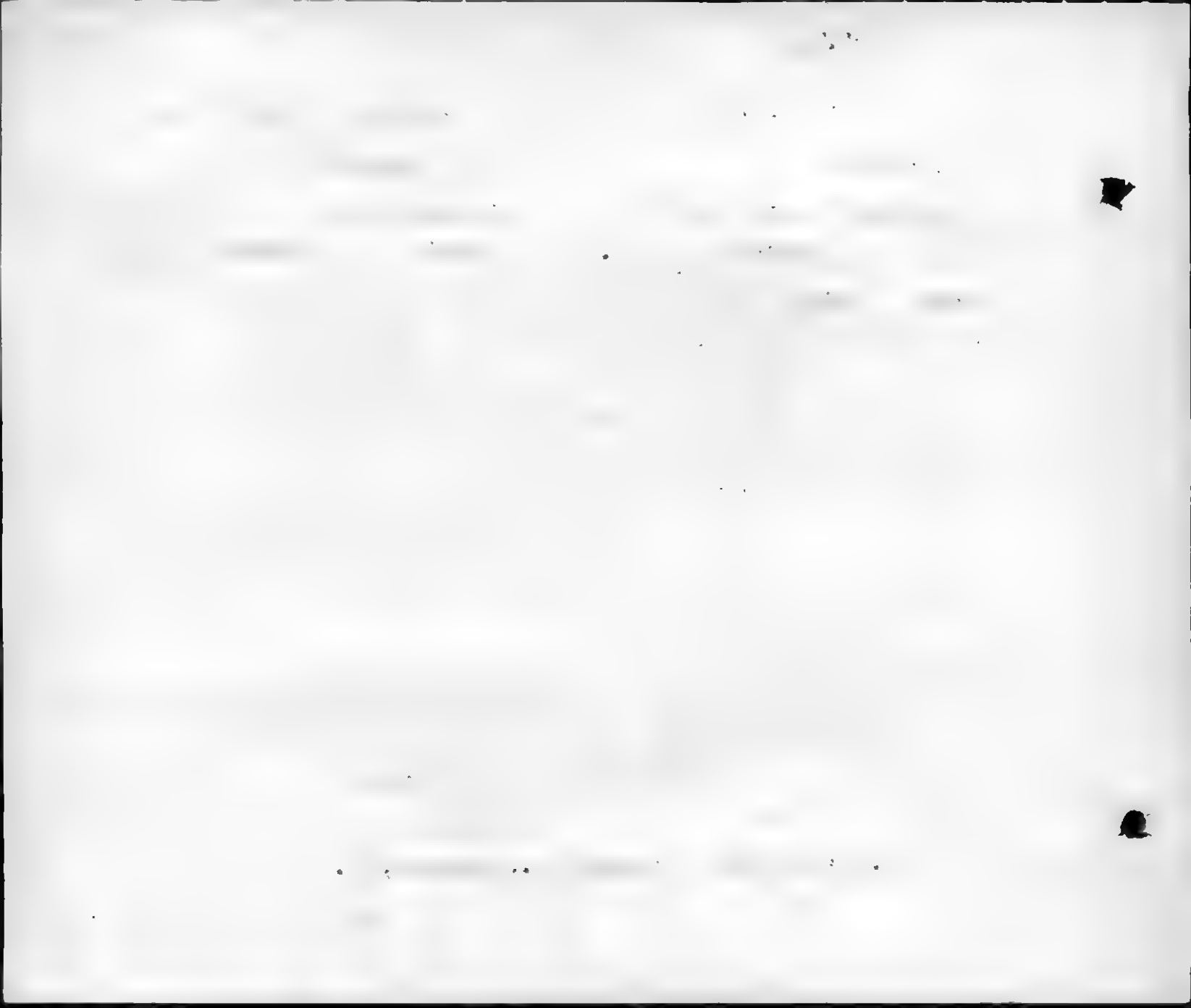
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13371

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1214 Summer Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) William		First B. Middle McInnis Last		4. DATE OF DEATH Month December Day 19 Year 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-1880		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE SALESMAN				10b. KIND OF BUSINESS OR INDUSTRY SHOE STORE		11. BIRTHPLACE (State or foreign country) CANADA	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME SAMUEL McINNIS				14. MOTHER'S MAIDEN NAME ANN MAC DONALD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT EMMA H. McINNIS		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 332X							INTERVAL BETWEEN ONSET AND DEATH 3 wks
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11-15-60 to 12-19-60 , that (I) (we) last saw the deceased alive on 12-19-60 , and that death occurred at 9:50 from the causes and on the date stated above.							
22a. SIGNATURE Frank Shipley				22b. DATE SIGNED 12-19-60			
22c. PHYSICIAN'S NAME (Type) Dr. Frank Shipley				22d. ADDRESS Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-20-60		23c. NAME OF CEMETERY OR CREMATORY BLOSSOM HILL		23d. LOCATION (City, town, or county) (State) CONCORD N.H.	
24. FUNERAL DIRECTOR'S SIGNATURE John M. G. L. & Sons Annapolis, Md.				25a. REC'D BY REGISTRAR DATE DEC 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



13410

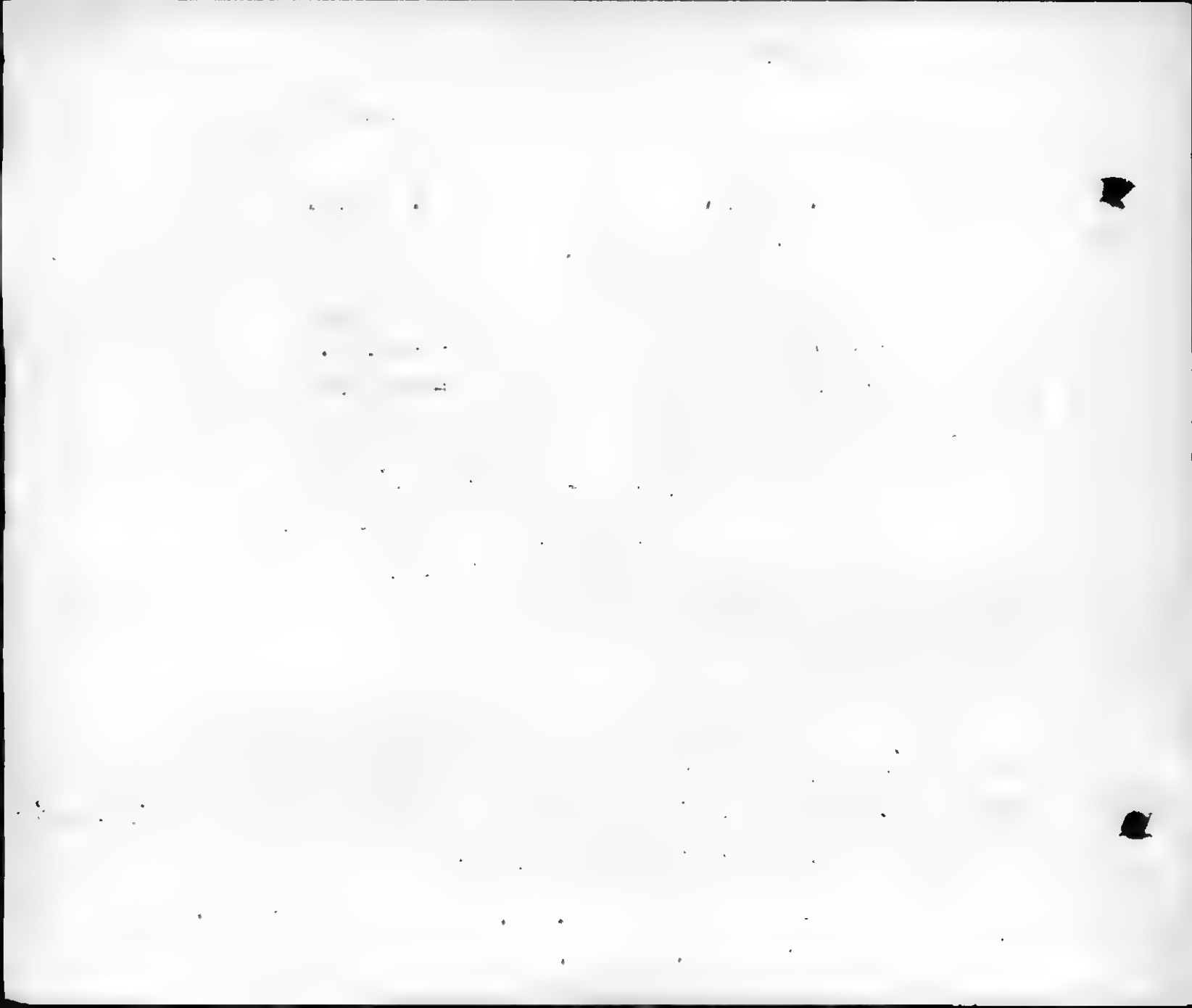
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY F.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 W. 3rd Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lilly Middle M. Last Meseke		4. DATE OF DEATH Month 12 Day 1 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/77
9. AGE (In years last birthday) yrs 83		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Hutton		14. MOTHER'S MAIDEN NAME James Mary Reinecker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT Address Family Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO Arterio sclerosis + Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. Hypertension (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 23, 1960 to Dec 1, 1960 , that I last saw the deceased alive on November 30, 1960 , and that death occurred at 1158 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1337 S. Charles St Baltimore, Md. DATE SIGNED 30 Dec 1960			
ACTUAL SIGNATURE John A. Scheurich M.D.			
PHYSICIAN'S NAME (Type) John A. Scheurich M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) B	22b. DATE THEREOF 12/5/60	22c. NAME OF CEMETERY OR CREMATORY Loudon Pk. Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.		24a. REC'D BY REGISTRAR DATE DEC 5 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13411

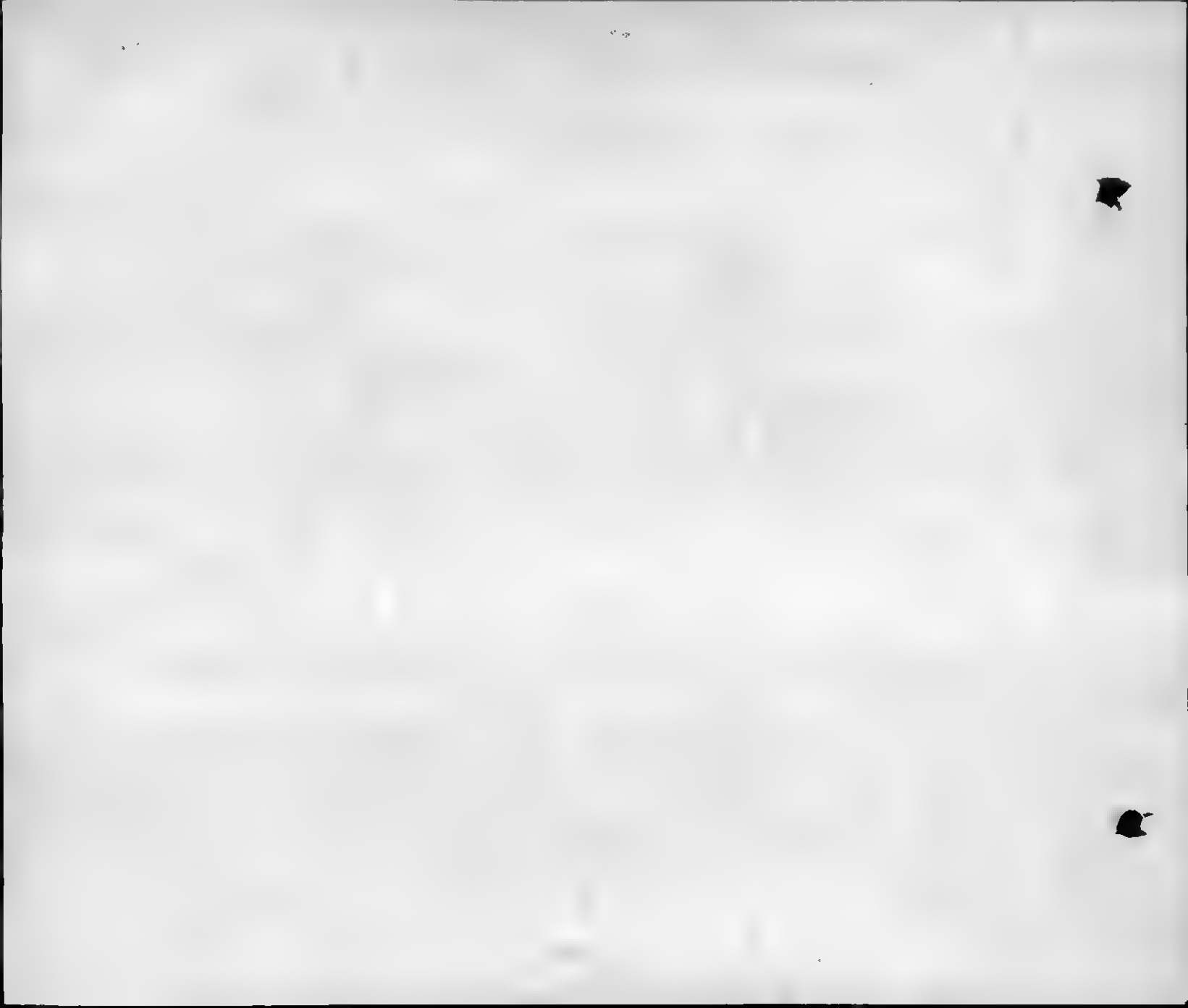
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13373

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Severn</u>				e. STREET ADDRESS <u>Severn</u>			
3. NAME OF DECEASED (Type or print) <u>Mac Miller Mills</u>				4. DATE OF DEATH <u>December 18th</u> 19 <u>60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/21/15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Severn</u>		11. BIRTHPLACE (State or foreign country) <u>Jacksonville, Fla.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Sally Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>2</u>		17. INFORMANT <u>Mrs. Emma Jones (sister)</u> Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>							
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave L. Faulkner</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave L. Faulkner</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>12/23/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>				22d. LOCATION (City, town, or country) (State) <u>Arbutus, Md</u>			
23. FUNERAL DIRECTOR <u>Joseph B. Rocks, Jr</u>				ADDRESS <u>1304 N. Central St</u>			
24a. REC'D BY REGISTRAR <u>DEC 21 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kneass</u>			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH Sudden

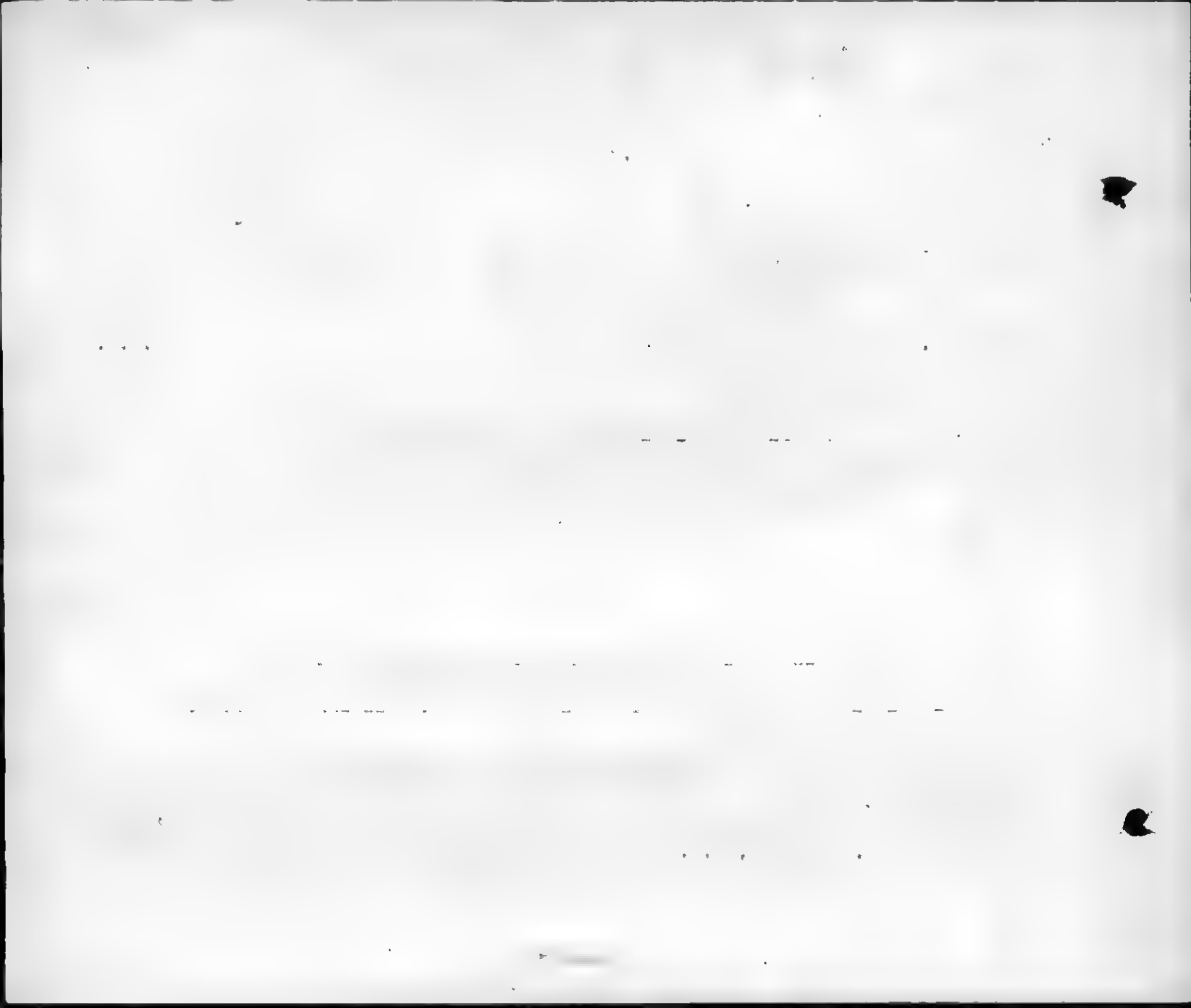


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13374

13412

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3 mos. 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 2216 Ruskin Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Harry		First		Middle		Last Nelson	
4. DATE OF DEATH 12 28 19 60		Month		Day		Year	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/21/85	
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR		IF UNDER 24 HRS		Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unempl. Pension				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Nelson				14. MOTHER'S MAIDEN NAME Eliza Gaither			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO 212-32-1763		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO (b) Heart Infarction DUE TO (c) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) factory street office bldg.				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/20 1960 to 12/28 1960 , that (I) (we) last saw the deceased alive on 12/28 1960 , and that death occurred at 4:45 PM , from the causes and on the date stated above							
22a. SIGNATURE L. Benedict, M.D.				22b. DATE SIGNED Dec 28, 1960			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL OR CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/31/60		23c. NAME OF CEMETERY OR CREMATORY ST. MATTHEWS		23d. LOCATION (City, town, or county) (State) JOHNSVILLE, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law				ADDRESS 802-Madison AVE.		25a. REC'D BY REG STRAR JAN 8 '61 DATE	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH																			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
13413 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13375																			
1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> c. LENGTH OF STAY IN TB <u>2 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel Beach</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Laurel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel Beach</u> d. STREET ADDRESS <u>1 Colonial Drive</u>														
3. NAME OF DECEASED (Type or print) <u>Robert T. Patterson</u> First Middle Last					4. DATE OF DEATH <u>December 17th</u> 19 <u>60</u> Month Day Year														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 8, 1902</u>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Driver</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Taxicab</u>			11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>											
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>Unknown</u>					17. INFORMANT <u>Alice I. Patterson</u> Address <u>1 Colonial Drive</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Unknown</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)												
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>12/15/60</u>				
ACTUAL SIGNATURE <u>Eustace H. Paulert, Jr.</u> M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>														
EXAMINER'S NAME (Type) <u>Eustace H. Paulert, Jr.</u>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>														
Address (Street, city, town, or county)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>12/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Glen Burnie, Prince Georges, Md</u>											
23. FUNERAL DIRECTOR <u>Emmerich, Inc. 1528 Sulphur Spring Rd</u>					ADDRESS					24a. REC'D BY REGISTRAR <u>DEC 20 '60</u>			24b. REGISTRAR'S SIGNATURE <u>William S. House</u>						



13414

CERTIFICATE OF DEATH

13376

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PINE GROVE VILLAGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PINE GROVE VILLAGE - BEADON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 SANDY BEACH RD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW E. PETERSON</u>				4. DATE OF DEATH Month Day Year <u>Dec. 25 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4 1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem SHIPYARD</u>		11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PETERSON</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-03-844</u>			
17. INFORMANT <u>CHARLES C. ALBAUGH</u>				Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4205 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary heart disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>16 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25 Dec. 1960</u> , to <u>25 Dec. 1960</u> , that I last saw the deceased alive on <u>25 Dec. 1960</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.				ADDRESS (Street, city or town, state) <u>2004 RITCHIE HIGHWAY</u>			
PHYSICIAN'S NAME (Type) <u>John Kehoe</u>				DATE SIGNED <u>GLEN BURNIE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec 29 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE - CAM, DORCY, IND.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Peterson</u> ADDRESS <u>1400 S. CHAPMAN ST BALTO</u>				24a. REC'D BY REGISTRAR <u>DEC 28 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Peterson</u>	

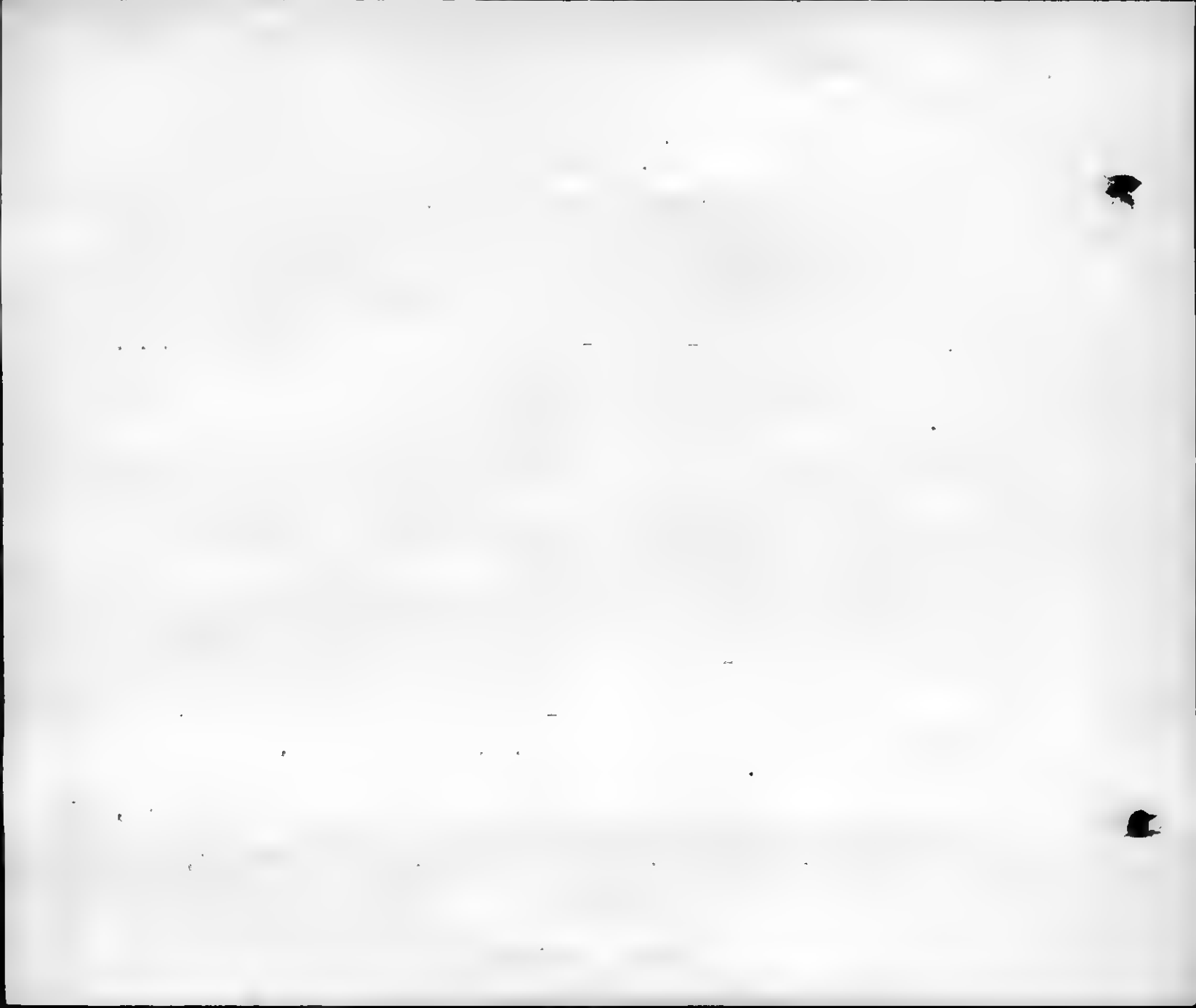


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
13415
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13377

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 15 yrs 7 mos. 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Unknown		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Plater Last Plater				4. DATE OF DEATH Month 12 Day 7 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1907	
9. AGE (In years la birthday) 53 yrs.		IF UNDER 1 YEAR Months 5 Days 3 Hours 2 Min 0		IF UNDER 24 HRS Hours 2 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Alexander Plater				14. MOTHER'S MAIDEN NAME Marguerite Harvey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 025X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Syphilitic & Arteriosclerotic Cardiovascular Disease DUE TO (c) General Paresis				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) factory, street, office bldg, etc.	
20f. (City or town) Crownsville				20g. (County) Calvert		20h. (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from Apr. 5, 1945 to Dec. 7, 1960 , that (I) (we) last saw the deceased alive on Dec. 7, 1960 , and that death occurred at 5:40 PM , from the causes and on the date stated above							
22a. SIGNATURE L. Benedict				22b. DATE December 8, 1960			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. (BURIAL) CREMATION, REMOVAL (Specify) 12-10-60		23b. DATE THEREOF 12-10-60		23c. NAME OF CEMETERY OR CREMATORY ALL E. Hope		23d. LOCATION (City, town, or county) (State) Summerville, Md	
24. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell				24a. REC'D BY REGISTRAR P. E. Frederick, Md.		24b. REGISTRAR'S SIGNATURE C. E. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13361

CERTIFICATE OF DEATH

13378

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>6 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Davidsonville</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Irene</u>			First Middle Last <u>QUEEN</u>		4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1911</u>		9. AGE (In years last birthday) <u>49</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chorwoman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>490x</u> DUE TO <u>Lobar Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from <u>Dec. 27, 1960</u> to <u>Dec. 28, 1960</u> , that it (we) last saw the deceased alive on <u>Dec. 28, 1960</u> , and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Martin</u>				22b. DATE SIGNED <u>12/28/60</u>		22c. PHYSICIAN'S NAME (Type) <u>James R. Martin</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>12-31-60</u>				23b. DATE THEREOF <u>12-31-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Natl. Harmony Mem. Pk. Highland Park Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Washington & Sons</u>				ADDRESS <u>4925 Klegwood Ave. N.E.</u>		25. REGISTRAR'S SIGNATURE <u>DATE JAN 3 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

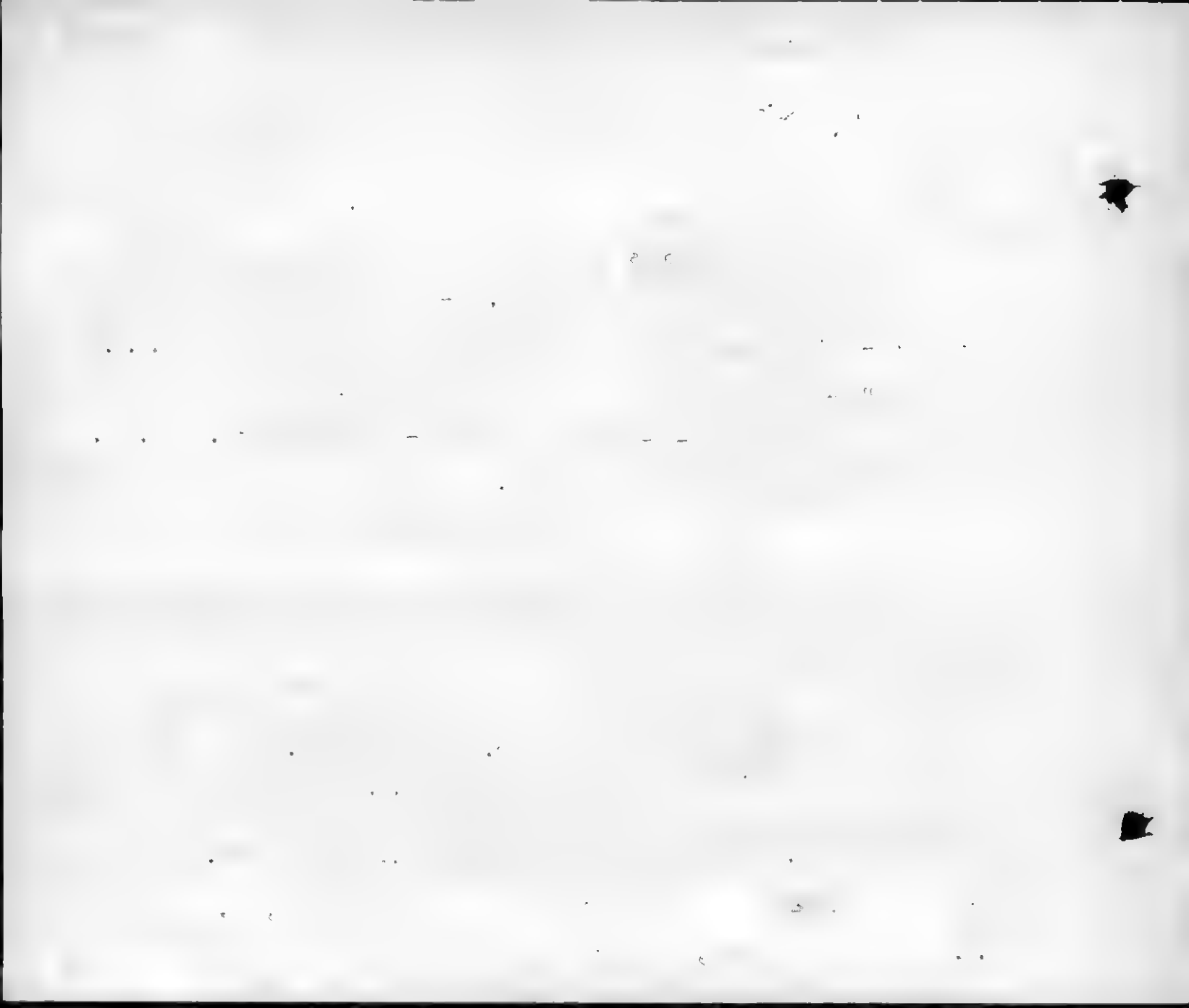
13362

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13379

1. PLACE OF DEATH a. COUNTY Anne A undel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Thomas Last QUEEN				4. DATE OF DEATH Month December Day 26 Year 19 60			
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 2 - 1887	9. AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer -- City of Annapolis			10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME Elijah Queen			14. MOTHER'S MAIDEN NAME Lovv Woodhouse				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-1192A		17. INFORMANT Adele Parker - 405 Oaklawn Ave. Anna. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443 X DUE TO (b) Hypertensive arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day 1 mo						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Richard attended the deceased from Dec. 19, 1960 to Dec. 25, 1960 that (I) (X) lost saw the deceased alive on Dec. 25, 1960 and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE James R. Martin		22b. DATE SIGNED 12/27/60		22c. PHYSICIAN'S NAME (Type) James R. Martin		22d. ADDRESS 6 Shaw St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-60		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town, or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III ADDRESS Annapolis, Maryland				25a. REC'D BY REG STRAR DATE JAN 4 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Evans	

MEDICAL CERTIFICATION



13363

CERTIFICATE OF DEATH

Reg. Dist. No.

13380

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Revell St.</u>				d. STREET ADDRESS <u>5 Revell St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HENRY DENISON RANDALL</u>				4. DATE OF DEATH Month Day Year <u>DEC 7 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20 1881</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MANAGER (RET.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GEN. ELECTRIC</u>		11. BIRTHPLACE (State or foreign country) <u>LEDYARD CONN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JASON L. RANDALL</u>				14. MOTHER'S MAIDEN NAME <u>HENRIETTA A. STODDARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>[If yes, give war or dates of service]</u>		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>HENRY D. RANDALL JR #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolic vascular accident & Rt. hemiparesis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypostatic pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>October</u> , 19 <u>60</u> , to <u>December</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec. 6</u> , 19 <u>60</u> , and that death occurred at <u>12:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Hedeman</u>				ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST. ANNAPOLIS MD.</u>			
PHYSICIAN'S NAME (Type) <u>JOHN HEDEMAN</u>				DATE SIGNED <u>12/8/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ledyard Center</u>		22d. LOCATION (City, town, or county) (State) <u>Ledyard Conn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>JOHN M. TAYLOR & SONS ANNAPOLIS MD.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13416
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13381

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville RFD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville RFD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Foxwell Road, Elvaton</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>R.</u> Last <u>Riddick</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10 Jan 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist (Ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Gatesville, N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rufus M. Riddick, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Roberts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. William Riddick</u> Address <u>P.O. Box 17 Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>4-24-4</u> DUE TO (b) <u>Chagrine Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Tumor</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 1956</u> to <u>December 1956</u> , that (I) (we) last saw the deceased alive on <u>Dec 3</u> 19 <u>56</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>William Riddick</u> M.D.		22b. DATE SIGNED <u>12-4-60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>24 Dec. 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ayden Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Ayden, N. Carolina</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 6 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13364
CERTIFICATE OF DEATH

13382

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Gambrills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RIDGLEY				4. DATE OF DEATH Month Day Year December 31 19 60			
5 SEX Female		6 COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1960	
9. AGE (In years last birthday) 3		IF UNDER 1 YEAR Months Days Hours Min 3 10		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James Ridgley				14. MOTHER'S MAIDEN NAME Alice Ridgley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 1			
17. INFORMANT Alice Ridgley				Address Gambrills Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity DUE TO (b) 3 hrs 10 min Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Dec. 31, 19 60 to Dec. 31, 19 60 that (I) (we) last saw the deceased alive on Dec. 31, 19 60 , and that death occurred at 8:50 P.M. M, from the causes and on the date stated above							
22a. SIGNATURE James W. Hayes				22b. DATE SIGNED 8:50 P.M.		22c. PHYSICIAN'S NAME (Type) James W. Hayes	
22d. ADDRESS Medical Bldg., Severna Park, Md.				22e. ADDRESS Medical Bldg., Severna Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-7-1961		23c. NAME OF CEMETERY OR CREMATORY Nelson Memorial		23d. LOCATION (City, town, or county) (State) Gambrills Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese				25a. REC'D BY REGISTRAR Anna		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13383

13365

1. PLACE OF DEATH a. COUNTY <u>A.A.Co. Annapolis, Md.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>63 Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSPITAL</u>				d. STREET ADDRESS <u>1541 Tiemen Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Isabell M. Roane</u>				4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 Sept. 1891</u>	
9. AGE (In years lost birthday) <u>69</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Noxema Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Farquar Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Alexander</u>				14. MOTHER'S MAIDEN NAME <u>Cora J. Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-4225</u>		17. INFORMANT <u>Mrs. Grace E. Carey</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic coma</u> 5-5-1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Hypertensive arteriosclerotic C.-V. Disease</u> DUE TO (c) <u>Acute appendicitis, peritonitis, general peritonitis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal Ulcer, chronic. Chronic generalized arthritis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 28, 1960</u> to <u>Dec. 25, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 25, 1960</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Merton T. Waite</u>				22b. DATE <u>12/25/60</u>		22c. PHYSICIAN'S NAME (Type) <u>MERTON T. Waite</u>	
22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE <u>12/25/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>28th Dec. 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		23d. LOCATION (City, town, or county) <u>Woodlawn, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. R. Singleton</u>				25a. REC'D BY REGISTRAR <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>W. R. Singleton</u>	



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

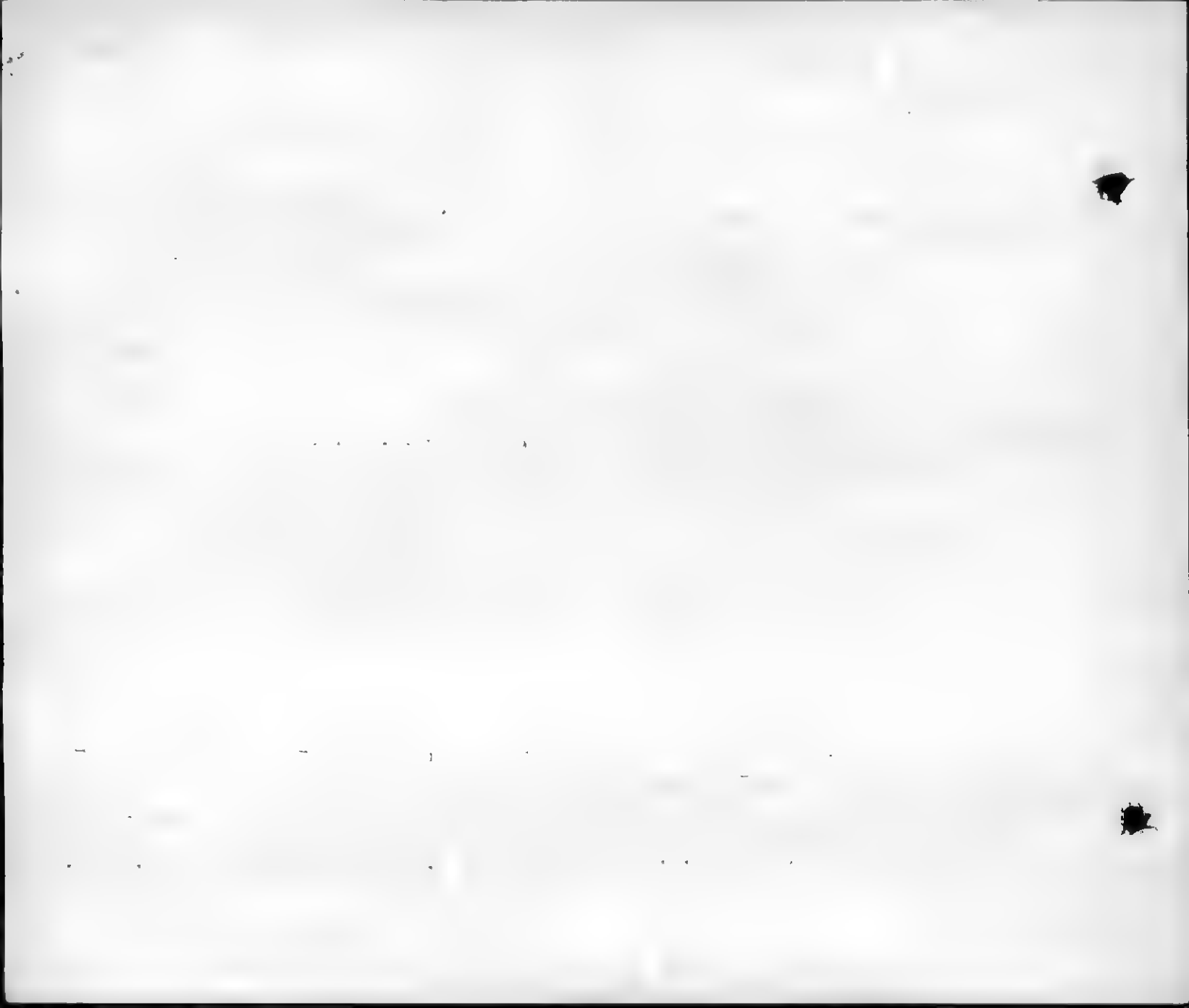
13417

CERTIFICATE OF DEATH

13384

Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 5 1/2 Months		2. USUAL RESIDENCE (Where deceased lived If institution: Res dence before admission) a. STATE Maryland b. COUNTY Baltimore		3. DATE OF DEATH Month December Day 23 Year 1960	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Plaza Manor Nursing Home		e. STREET ADDRESS 1300 W. Baltimore Street 23		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Irene Robinson		4. DATE OF DEATH Month December Day 23 Year 1960		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH September 10, 1883		9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77		11. IF UNDER 24 HRS Days 77		12. IF UNDER 30 HRS Hours 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Housewife		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? Unknown U.S.A.			
13. FATHER'S NAME Unknown Thomas A. Kelly		14. MOTHER'S MAIDEN NAME Unknown IRENE E. Christmas		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Rainey-B.C.D.P.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Unknown		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Seizure disorder		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month 12 Day 23 Year 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 400 N. Carrollton Avenue Balto. 23, Md.	
20f. CITY or town Baltimore		20g. (County) Baltimore		20h. (State) Md.		21. I certify that (I) (this hospital) attended the deceased from 7-8-1960 to 12-23-1960 , that (I) (we) lost saw the deceased alive on 12-23-1960 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James M. Pair		22b. DATE SIGNED 12-23-1960		22c. PHYSICIAN'S NAME (Type) James M. Pair, M.D.		22d. ADDRESS 400 N. Carrollton Avenue Balto. 23, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-23-1960		23c. NAME OF CEMETERY OR CREMATORY Louisa B. Cem.		23d. LOCATION (City, town, or county) FREDERICK AVE. Balto. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph N. James Jr.		24a. ADDRESS 312 S. Highland		25a. REC'D BY REGISTRAR DEC 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



13418

CERTIFICATE OF DEATH

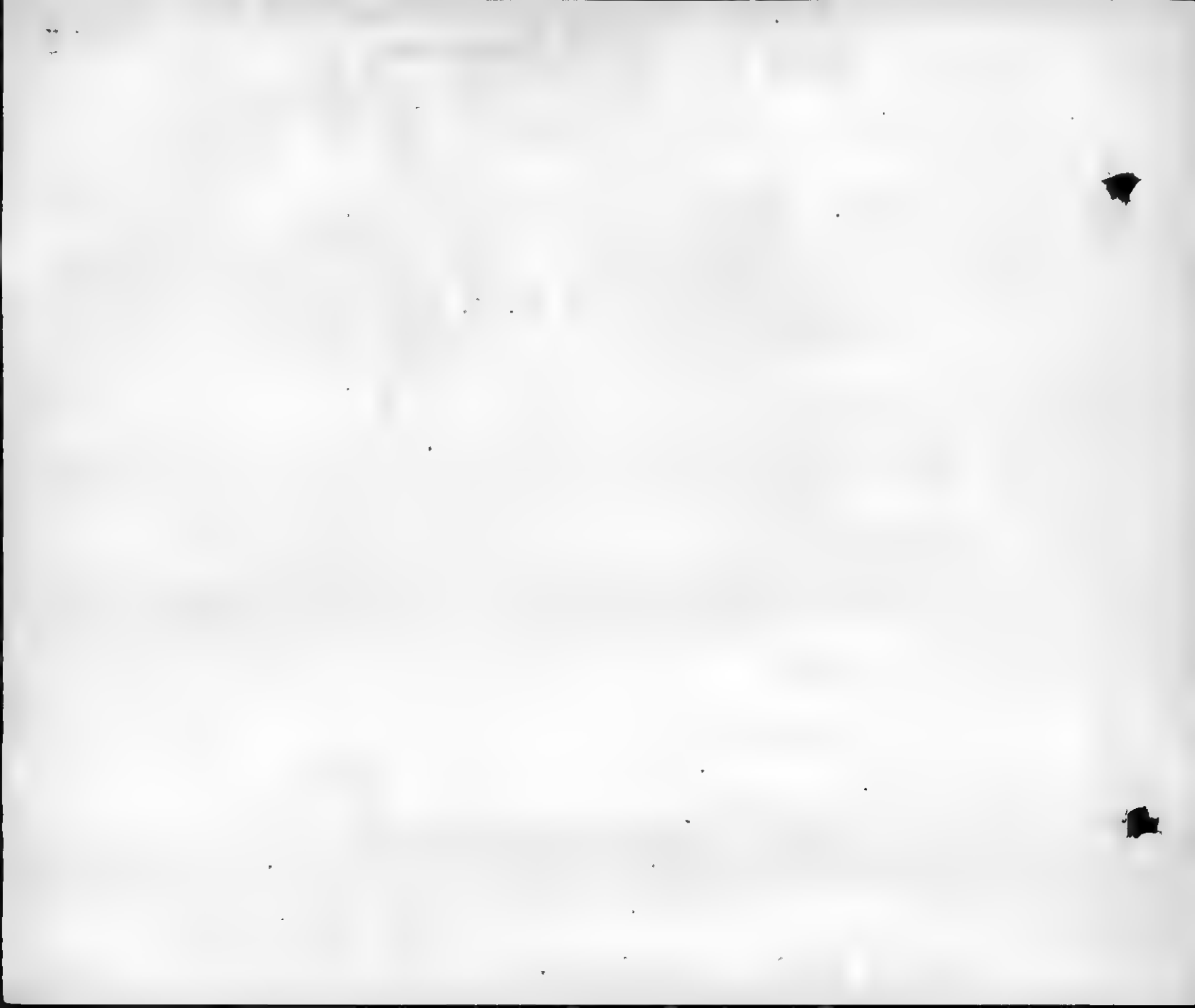
13385

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold		c. LENGTH OF STAY IN 1b Arnold		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold		d. STREET ADDRESS Deep Creek Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AMY LEE ROSS		First		Middle		Last		4. DATE OF DEATH Month DECEMBER 11		Day 1960		Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29, 1958		9. AGE (In years lost birthday) 2 yrs.		IF UNDER 1 YEAR Months 2		IF UNDER 24 HRS Days 2		Hours 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Robert B. Ross		14. MOTHER'S MAIDEN NAME Madolin Moreland		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service) none		17. INFORMANT Address Mr. Robert B. Ross Father same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hydrophalus and 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial DUE TO (c) General Infection -												INTERVAL BETWEEN ONSET AND DEATH BIRTH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 10/29 , 19 58 , to 12/11 , 19 60 , that I last saw the deceased alive on 12/8 , 19 60 , and that death occurred at M. , from the causes and on the date stated above.																	
ACTUAL SIGNATURE Philip Briscoe				M.D. 95 Calhoun St				ADDRESS (Street, city or town, state) Annapolis, Maryland				DATE SIGNED 12/15/60					
PHYSICIAN'S NAME (Type) Philip Briscoe MD.																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-16-60				22c. NAME OF CEMETERY OR CREMATORY Asbury Methodist Cemetery				22d. LOCATION (City, town, or county) (State) Arnold, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DATE DEC 19 '60				24b. REGISTRAR'S SIGNATURE C. J. 8 Huns					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

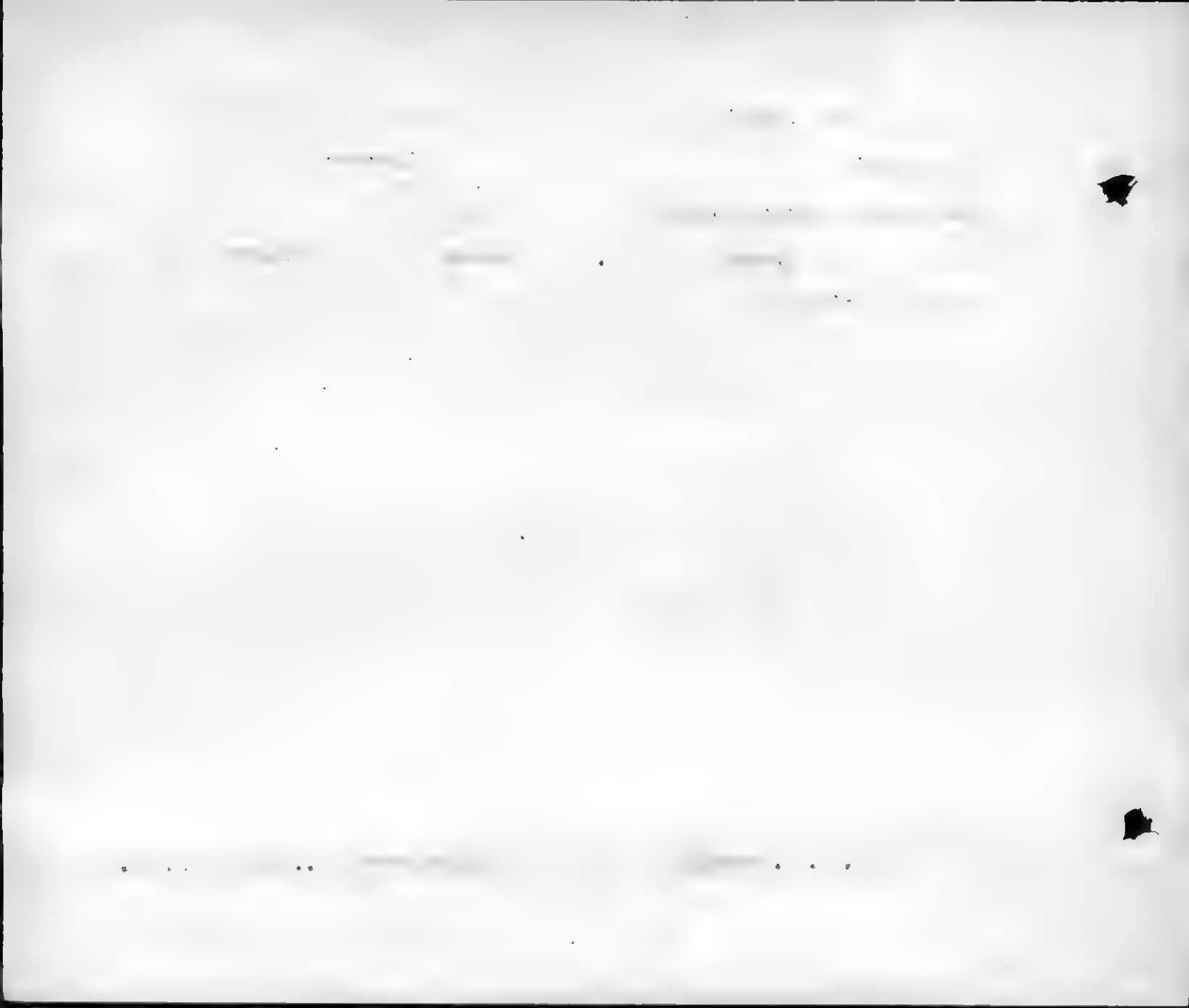


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reburied by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13366
13386
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS R. F. D.			
3. NAME OF DECEASED (Type or print) First Herbert Middle C. Last Runyan				4. DATE OF DEATH Month December Day 16 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-12-1895	
9. AGE (In years last birthday) 65 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Ret.		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Isaac J. Runyan		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. J.		17. INFORMANT Arthur J. Runyan		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatic failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of the Liver (Laennec's) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 month 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 10/31 , 19 60 , to 12/16 , 19 60 , that (I) (the) last saw the deceased alive on 12/16 , 19 60 , and that death occurred at 7P M, from the causes and on the date stated above							
22a. SIGNATURE Richard L. Hockman				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. R. I. Hockman				22d. ADDRESS 100 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, or REMOVAL (Specify)		23b. DATE THEREOF Dec 20-1960		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemt		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons				25a. REC'D BY REGISTRAR DATE DEC 23 '60		25b. REGISTRAR'S SIGNATURE William J. H. us	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1003. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

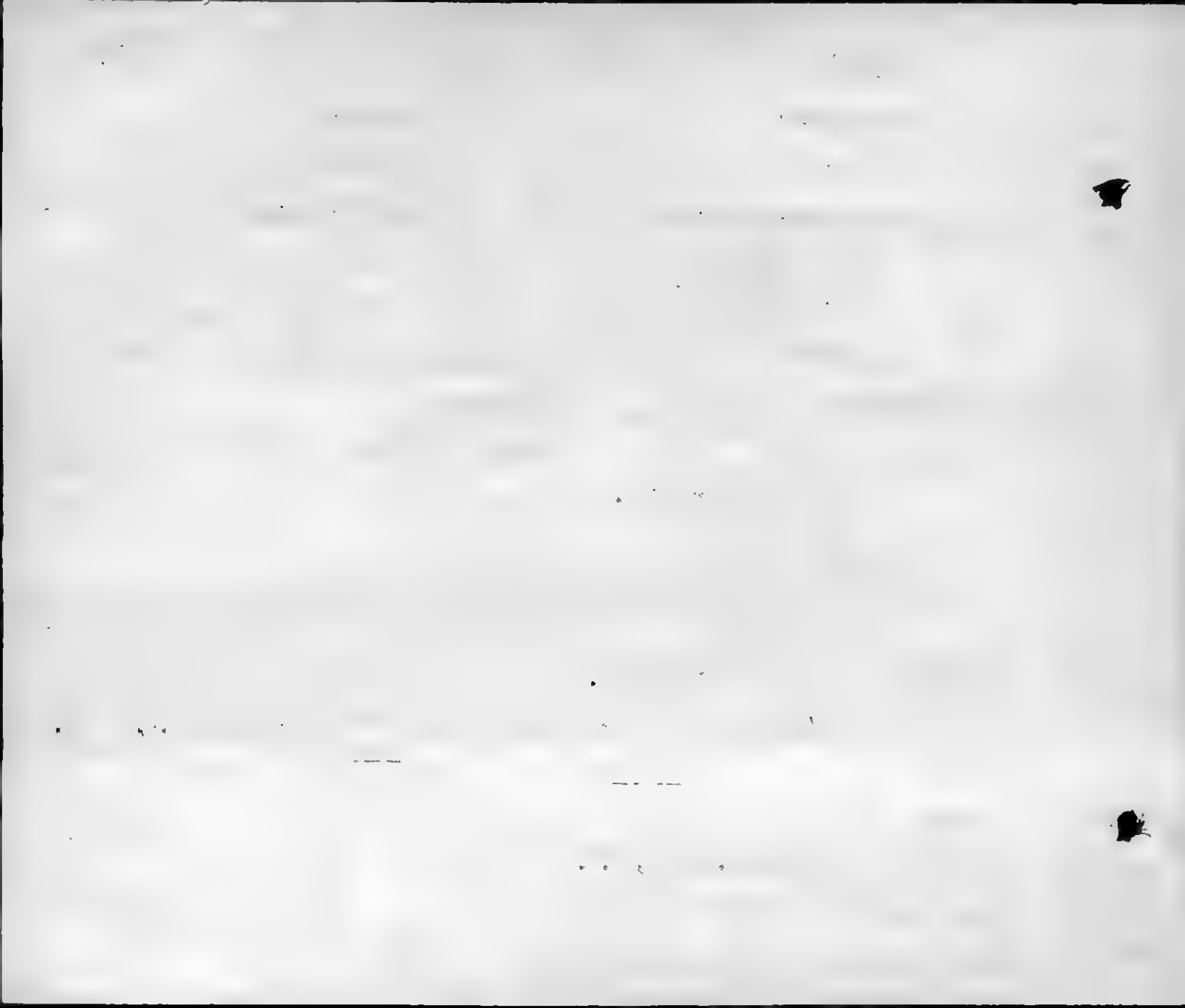
VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13387

Item 8 Film 6277 12-20-60 et

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN IL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3451 Park Heights Avenue		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MEYER		First		Middle		Last SACKS		4. DATE OF DEATH December 12 19 60	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1915		9. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) T.V. Repair		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Isaac		14. MOTHER'S MAIDEN NAME Jennie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Helew Sacks Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning. 851X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Boat sunk.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 12/12/60 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.) Chesapeake Bay		20f. (City or town) (County) (State) Off Annapolis A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Charles S. Petty		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		Address (Street, city, town, or county)		DATE SIGNED 12/13/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-60		22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or country) (State) Balto Md			
23. FUNERAL DIRECTOR Jack Lewicki		ADDRESS 2100 Euterpe Pl		24a. REC'D BY REGISTRAR DEC 16 '60		24b. REGISTRAR'S SIGNATURE William L. Hanna			

MEDICAL CERTIFICATION



13419

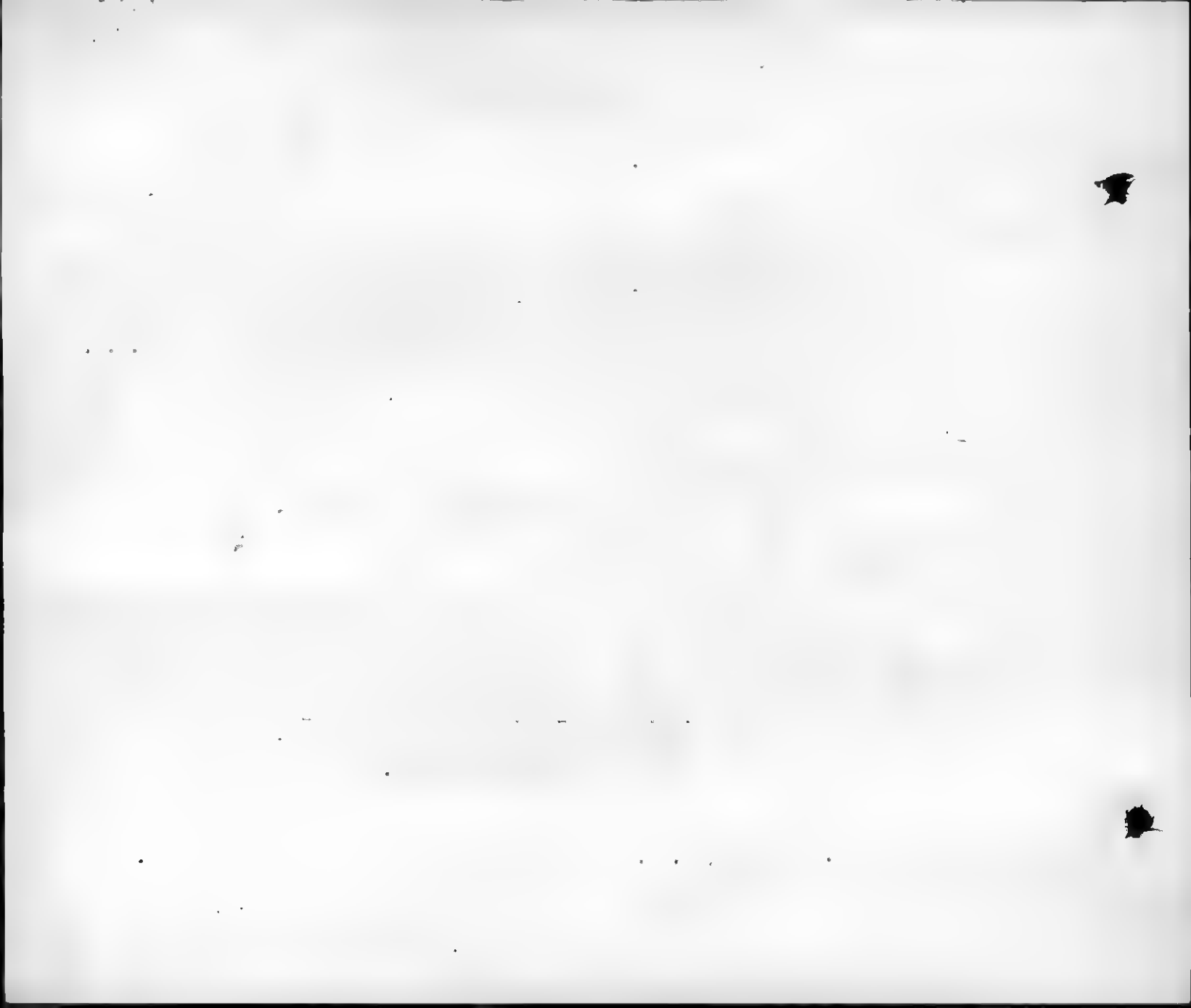
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13388

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 2 years 11 mo. 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 521 Bethel Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Chambers Sander				4. DATE OF DEATH Month Day Year 12 7 1960			
5 SEX Male		6 COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated		8 DATE OF BIRTH March 4, 1877	
9 AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY -----		11 BIRTHPLACE (State or foreign country) North Carolina	
12 CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Chambers				14. MOTHER'S MAIDEN NAME Maggie Robinson			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes-Spanish-American		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 7/9 1957 , to 12/7 1960 , that (I) (we) last saw the deceased alive on 12/7 1960 , and that death occurred at 10A M , from the causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE 12/7/60			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-10-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City, town, or county) (State) A. A. County, Md	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph B. Locks Jr.</i>		ADDRESS 1304 N. Central Ave.		25a. REC'D BY REGISTRAR DEC 9 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

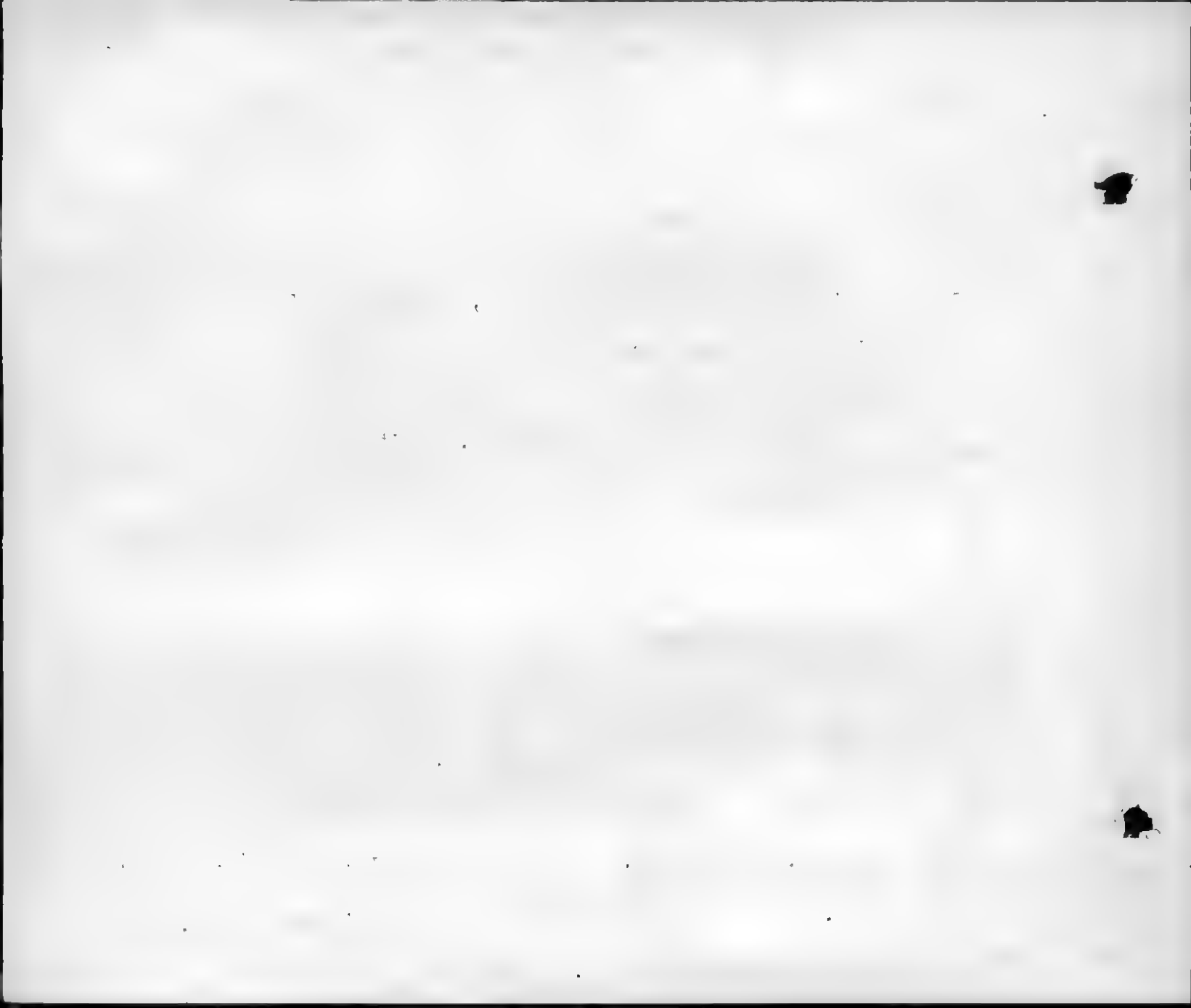
13420 CERTIFICATE OF DEATH

13389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVA			c. LENGTH OF STAY IN 1b X			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVA		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIVA GUEST HOUSE				d. STREET ADDRESS 1 NONE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ANNA Middle SAULIT Last				4. DATE OF DEATH Month DECEMBER Day 10 Year 19 60				
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1887		
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Latvia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Bihnatt				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr John E. Saulit Son Same as # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 174x DUE TO Cerebrum & the uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Metastasis to Intestine Tract & Liver DUE TO Liver INTERVAL BETWEEN ONSET AND DEATH 2 yrs 6 months								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis - Cerebral Vascular Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Nov. 10, 1960 to Dec 10, 1960 that I last saw the deceased alive on Dec 10, 1960 , and that death occurred at 9:30 P.M. from the causes and on the date stated above								
ACTUAL SIGNATURE Albert L. Anderson M.D.				ADDRESS (Street, city or town, state) Southgate Ave, Annapolis, Maryland				
DATE SIGNED 12/14/60								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 16 - 1960		22c. NAME OF CEMETERY OR CREMATORY All Hallowes Cemetery		22d. LOCATION (City, town, or county) (State) Davidsonville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DEC 19 '60		24b. REGISTRAR'S SIGNATURE John S. Kenna		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13421

13390

Items 1, 2 film 6278 1-5-61 et 3v014

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 3 Mos. 6 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Crownsville, State Md. b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. d. STREET ADDRESS 3316 Anchenbury Ter.	
3. NAME OF DECEASED (Type or print) First John Middle W Last Saunders		4. DATE OF DEATH Month 12 Day 24 Year 1960	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		9. AGE (In years) 83 IF UNDER 1 YEAR: Months 8 Days 3 Hours 3 Min 3	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Gray		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Medical Record		Address Crownsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac & Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Extreme old age DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8-10 hrs Since admission	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME ASSOCIATED TO GENERALIZED ARTERIOSCLEROSIS			
19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above			
22a. SIGNATURE L. Benedict M D		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. BENEDICT M D		22d. ADDRESS CROWNVILLE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-28-60	
23c. NAME OF CEMETERY OR CREMATORY Arbitus		23d. LOCATION (City, town, or county) (State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE Geo. S. Nelson		25a. REC'D BY REGISTRAR DEC 27 '60	
ADDRESS 1348 N. Calhoun St		25b. REGISTRAR'S SIGNATURE W. S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 6276 12-9-60 et

13422

CERTIFICATE OF DEATH

Reg. Dist. No.

13391

1 PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shipley, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shipley</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Shipley Farm</u> <u>Fairmount Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Amanda</u> Last <u>Shipley</u>		4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Schoolteacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Shipley, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Luther Shipley</u>		14. MOTHER'S MAIDEN NAME <u>Annie S. Linthicum</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. J. Clinton Roberts</u>		Address <u>Fairmount Road</u> <u>Shipley, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>54 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , to <u>1960</u> , that I last saw the deceased alive on <u>12/2/60</u> , 19 <u> </u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>101 Cedar St. Glen Burnie Md</u> DATE SIGNED <u>Dec 5, 1960</u>			
ACTUAL SIGNATURE <u>James S. Beilingh</u> M.D.		PHYSICIAN'S NAME (Type) <u>James S. Beilingh</u> <u>101 Cedar St. Glen Burnie</u> <u>Dec 5, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Dickner, Inc.</u>		ADDRESS <u>Balto 17 Md</u>	24a. REC'D BY REGISTRAR DATE <u>DEC 6 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

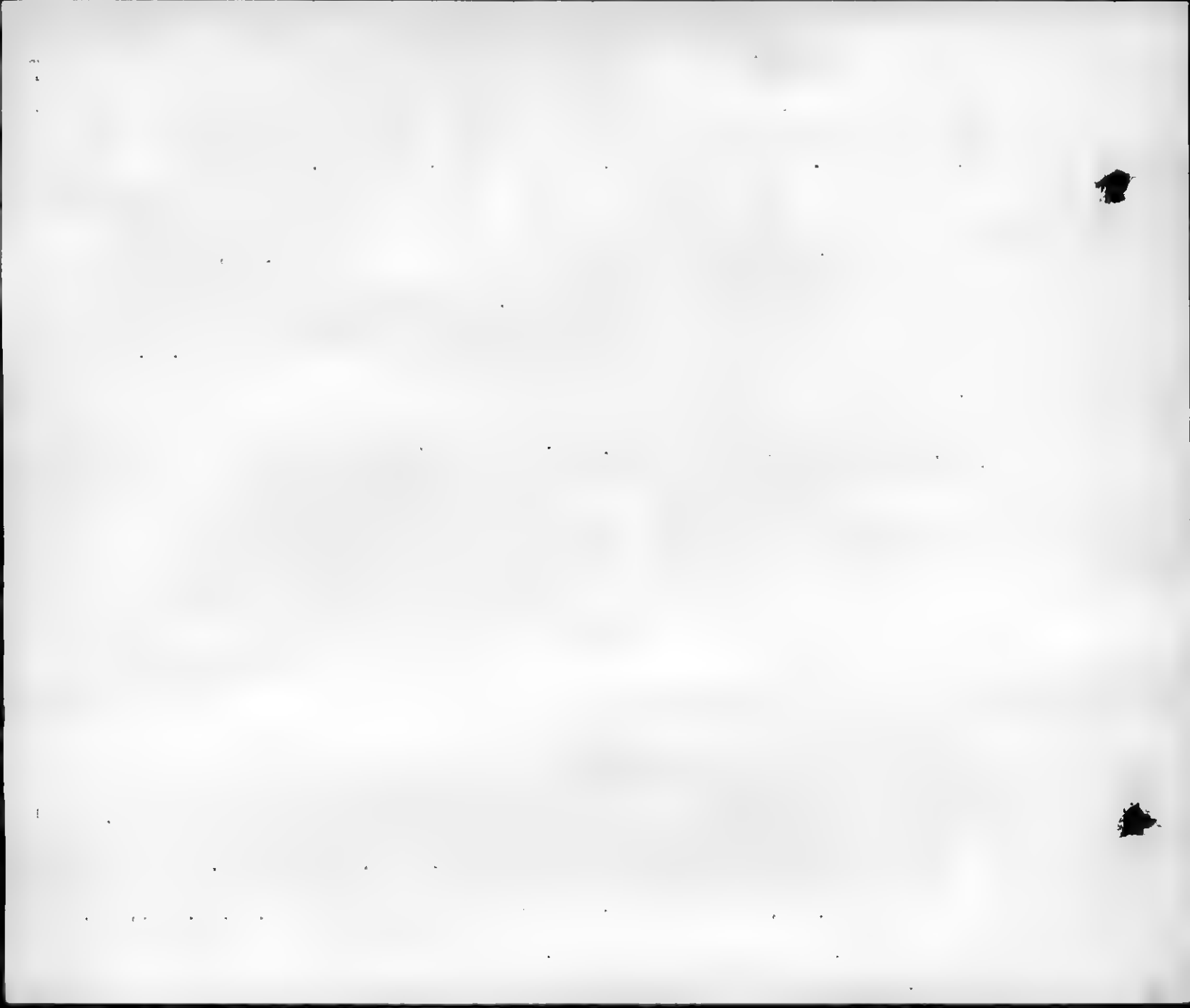
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13423

13392

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Hgts.</u>				c. LENGTH OF STAY IN 1b <u>5 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4950 Brookwood Road</u>				d. STREET ADDRESS <u>4950 Brookwood Road</u>			
3. NAME OF DECEASED (Type or print) <u>Ella Madeline Shores</u>				4. DATE OF DEATH Dec. 16, 1960			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 31, 1902</u>	
9. AGE (In years lost birthday) <u>58</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>John Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Marshall</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <input type="checkbox"/>	
16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Mr. William B. Shores</u>		Address <u>Same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420...</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>7 years</u>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1955</u> to <u>Dec 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec 15, 1960</u> , and that death occurred at <u>3 a.m.</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Benjamin Berdanna</u>		22b. DATE SIGNED <u>Dec. 16, 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>BENJAMIN BERDANNA</u>		22d. ADDRESS <u>5010 A. Gov. Ritchie Hwy.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 19, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. A. A. Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>		ADDRESS <u>4001 Ritchie Hwy. (25)</u>		25a. REC'D BY REGISTRAR <u>DATE DEC 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13368 CERTIFICATE OF DEATH

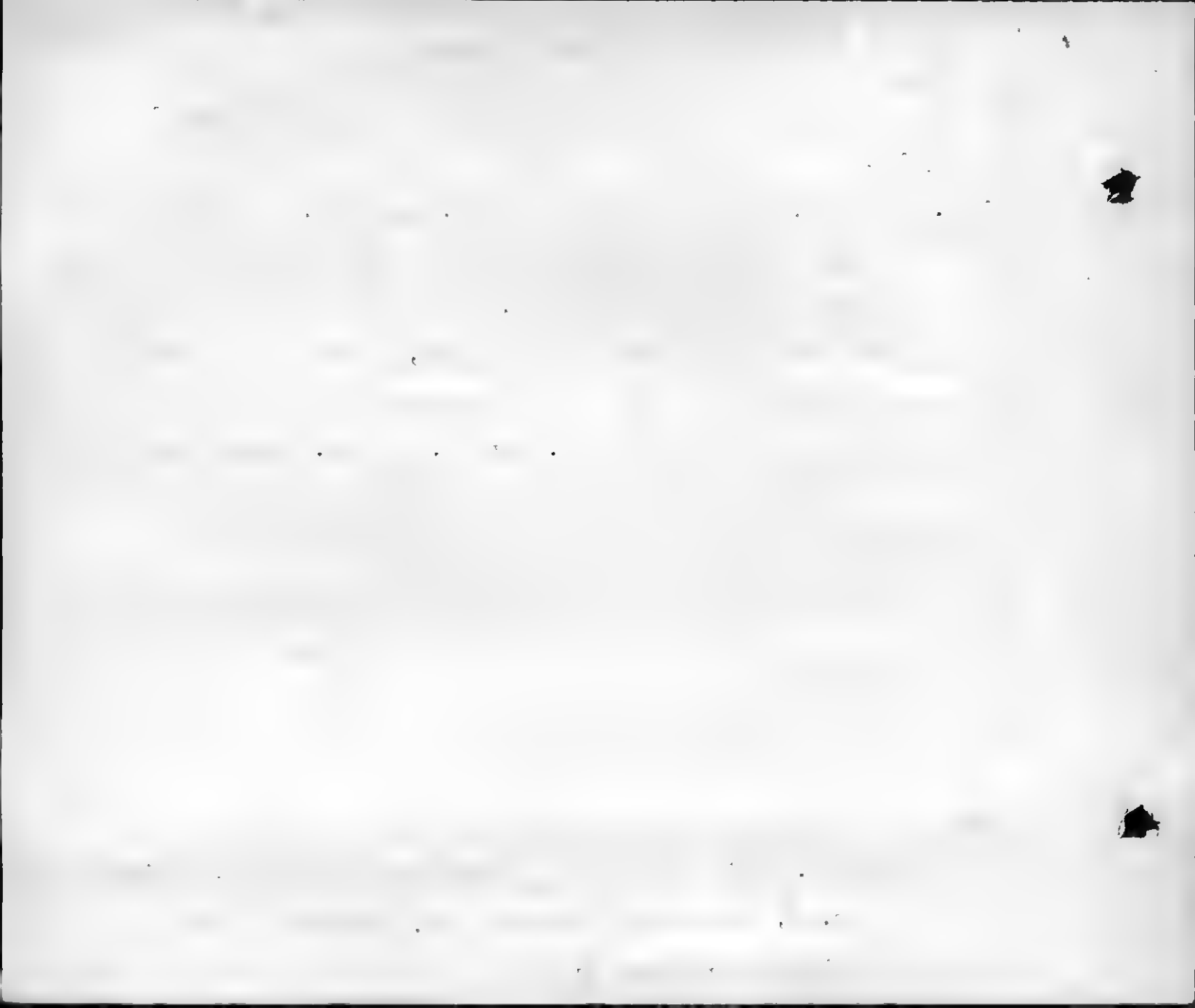
13393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis,</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 N. Brewer Ave.</u>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>14 N. Brewer Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>I</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>8</u> Year <u>1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 26, 1879</u>		9. AGE (In years lost birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> IF UNDER 24 HRS: Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Crisfield, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George Hayman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mariner</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Walter B. Smith Sr. Husband same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs</u> <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 19, 1958</u> to <u>Dec. 8, 1960</u> that I lost <u>saw</u> the deceased <u>olive on</u> <u>Dec. 8, 1960</u> and that death occurred at <u>12:35 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>12-10-60</u>									
ACTUAL SIGNATURE <u>James A. Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>James A. Martin</u> <u>5 Shaw Street, Annapolis, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 12, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis National Cemet.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

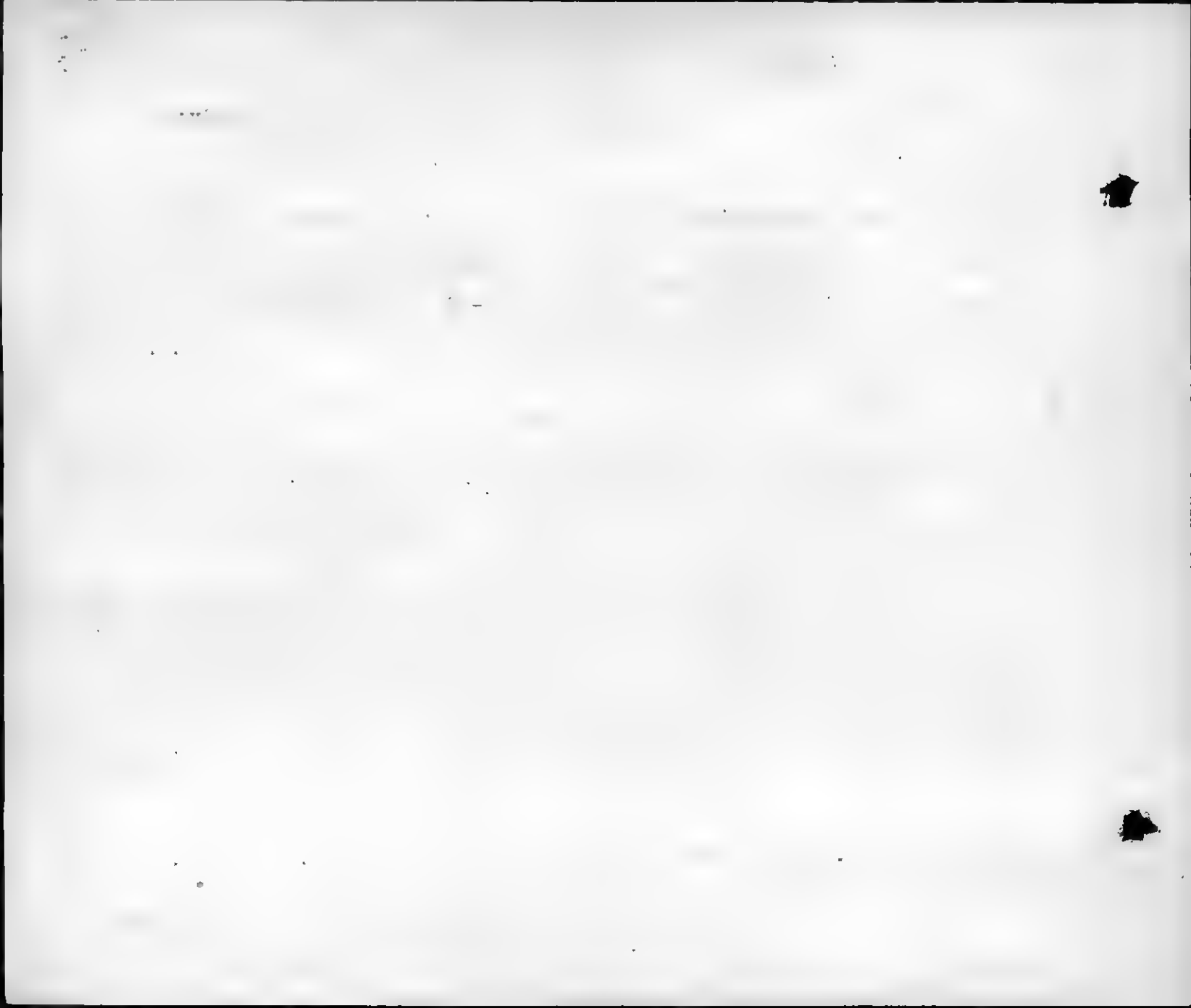


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13369
13394
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 9th. and Dayton			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Leroy Middle O. Last Soper				4. DATE OF DEATH Month 12 Day 2 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-20-97	
9. AGE last birthday 63		10. IF UNDER 1 YEAR Months 5 Days 16 Hours 54 Min. 7		11. IF UNDER 24 HRS Hours 54 Min. 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic				10b. KIND OF BUSINESS OR INDUSTRY GAS STATION Maryland			
11. BIRTH PLACE (State or foreign country) U.S.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Owen Soper				14. MOTHER'S MAIDEN NAME Elizabeth Cranford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W. W. I				16. SOCIAL SECURITY NO. W. W. I			
17. INFORMANT Mrs. Leroy Soper, North Beach, Maryland				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) LYMPHATIC LEUKEMIA DUE TO (c) 5-16-56 54 7 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5-16-56 54 7 mo							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-16 , 19 56 to 12-3 , 19 60 that (I) (we) last saw the deceased alive on 12-2 , 19 60 , and that death occurred at 4 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Edith Rodler				22b. DATE SIGNED 12-3-60			
22c. PHYSICIAN'S NAME (Type) Dr. Edith Rodler				22d. ADDRESS Franklin Street, Annapolis, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 6, 1960			
23c. NAME OF CEMETERY OR CREMATORY Emmanuel Church Cemetery Plum Point, Maryland				23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home				25a. REC'D BY REGISTRAR Owings, Maryland			
25b. REGISTRAR'S SIGNATURE Charles S. Thomas				DATE DEC 7 '60			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13424

CERTIFICATE OF DEATH

13395

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brownwood</u> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Tola</u> First <u>Stansbury</u> Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-27-1903</u> 37 yrs.
9. AGE (In years last birthday) <u>57</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Goshua</u>	
14. MOTHER'S MAIDEN NAME <u>Mattie Jackson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>William Stansbury Brownwood</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic Bone Disease</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>about 2 yr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-8-60</u> to <u>12-16-60</u> , that I last saw the deceased alive on <u>12-8-60</u> , 19 <u>60</u> , and that death occurred at <u>6 L Cochran St</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G.T. Allen</u> M.D.		DATE SIGNED <u>12-16-60</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-13-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>	22d. LOCATION (City, town, or county) (State) <u>St. Margaret</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u> ADDRESS <u>Arundel</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 19 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William S. K. M.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13376

13396

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton		b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN 1b 2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Annapolis 10, (Loom Town)		d. STREET ADDRESS 1 Same	
3. NAME OF DECEASED (Type or print) William Stoops Last East Middle Daniel		4. DATE OF DEATH December 19 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 28th June 1915 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired army man		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Highland Township, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME H. Russell Stoops		14. MOTHER'S MAIDEN NAME Mae E. Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1941-11		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mr. H. Russell Stoops, Gettysburg, R.D. 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation by smoke DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was trapped in his room when the hotel was burning. 20c. TIME OF INJURY Month, Day, Year 4-15 A.M. Hour 12/19/60 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Annapolis 10, Odenton, Md., Anne Arundel County. 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 22a. REC'D BY REGISTRAR DATE DEC 23 '60 22b. REGISTRAR'S SIGNATURE Arthur S. Kraus 22c. NAME OF CEMETERY OR CREMATORY Fairfield Union ADDRESS Emmitsburg, Md. 22d. LOCATION (City, town, or country) (State) Fairfield, Adams Co. Pa. 22e. BURIAL, CREMATION, REMOVAL (Specify) Burial 22f. DATE THEREOF 12/22/60 23. FUNERAL DIRECTOR C. E. Wilson 24. NAME OF CEMETERY OR CREMATORY Fairfield Union ADDRESS Emmitsburg, Md. 24a. REC'D BY REGISTRAR DATE DEC 23 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

VS. A15ME
5M 7/59



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or the registrar of burial, cremation, or removal.

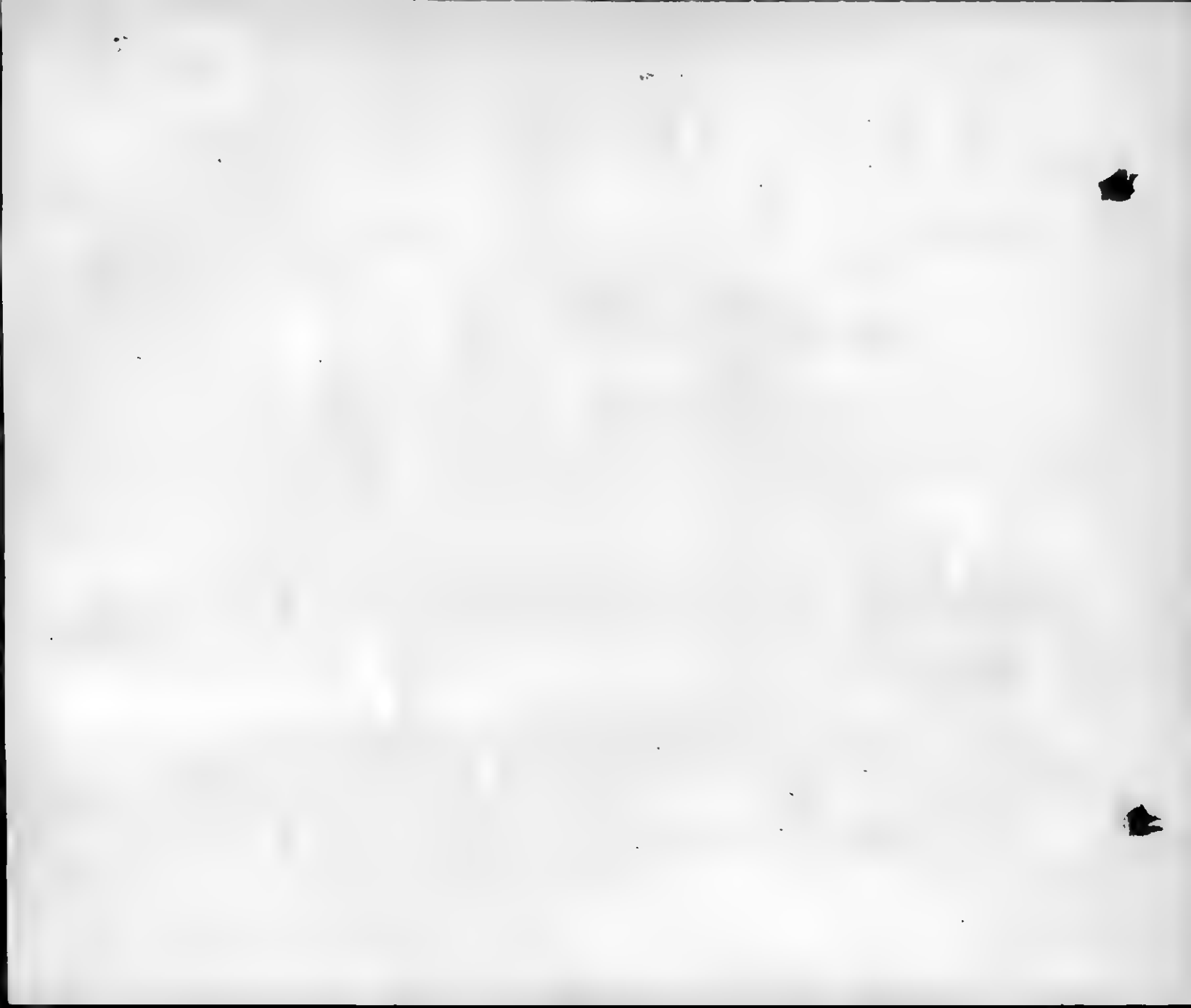
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13370 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13397

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 1b <u>WOODLAND BEACH</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>			d. STREET ADDRESS <u>3514 SALISBURY RD</u>		
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>ROBERT</u> Middle <u>STORMS</u> Last			4. DATE OF DEATH <u>12</u> Month <u>29</u> Day <u>1960</u> Year		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1960</u>		9. AGE (In years last birthday) <u>7</u> yrs. <u>29</u> Months <u>29</u> Days <u>29</u> Hours <u>29</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>	
13. FATHER'S NAME <u>ALFRED W. STORMS</u>		14. MOTHER'S MAIDEN NAME <u>MARGIE JACK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ALFRED W. STORMS</u> Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> <u>493X</u> DUE TO <u>Neumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/29/60</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12-30-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	23. REGISTRAR'S SIGNATURE <u>John M. Glat + Sons</u>	
23. REGISTRAR'S SIGNATURE <u>John M. Glat + Sons</u>		24a. REC'D BY REGISTRAR <u>AN 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Brown</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13425

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13398

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 7 mos. 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31 d. STREET ADDRESS 30 S. Register Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle Walters Last Walters		4. DATE OF DEATH Month 12 Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 15 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing House		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis Associated with Cerebral Hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 22 1960 to December 7 1960 , that (I) (we) last saw the deceased alive on December 7 1960 , and that death occurred at 1:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE L. Benedict		22b. DATE SIGNED 12/8/60	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 12/16/60	
23c. NAME OF CEMETERY OR CREMATORY St. Maryland		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese		25a. REC'D BY REGISTRAR DEC 21 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



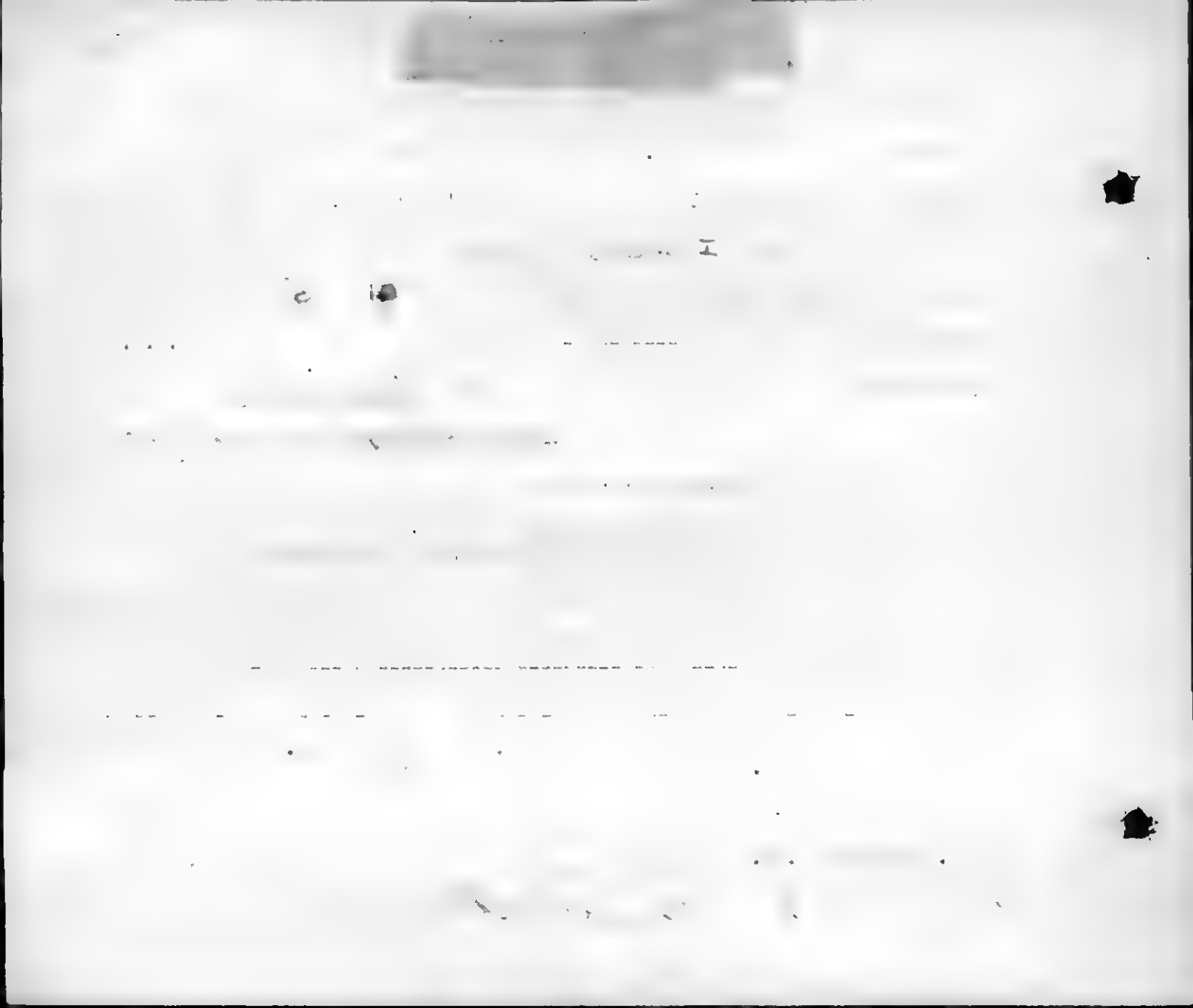
may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13426

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13399

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 mo. 28 days d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 122 O'Berry Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sadie Middle Isabelle Last Warfield				4. DATE OF DEATH Month 12 Day 15 Year 1960			
5 SEX Female		6 COLOR OR RACE Negro		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1921	
9 AGE (In years birth day) 39		IF UNDER 1 YEAR Months 1 Days 3		IF UNDER 24 HRS. Hours 3 Min 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Moore				14. MOTHER'S MAIDEN NAME Laura Madison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address 122 O'Berry Ct.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443 IMMEDIATE CAUSE (a) Pneumonia Hypostatic DUE TO Old Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Cardiovascular Disease (c) Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- 19 60 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from Oct. 17, 1960 to Dec. 15, 1960 , that (I) (we) last saw the deceased alive on Dec. 15, 1960 , and that death occurred at 3:20 M, from the causes and on the date stated above.							
22a. SIGNATURE L. Benedict, M. D.				22b. DATE SIGNED 12/15/60			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/18/60		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town, or county) (State) ANN Md	
24. FUNERAL DIRECTOR'S SIGNATURE William Reese & Ann Md.				25a. REC'D BY REGISTRAR DATE DEC 19 '60		25b. REGISTRAR'S SIGNATURE William S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

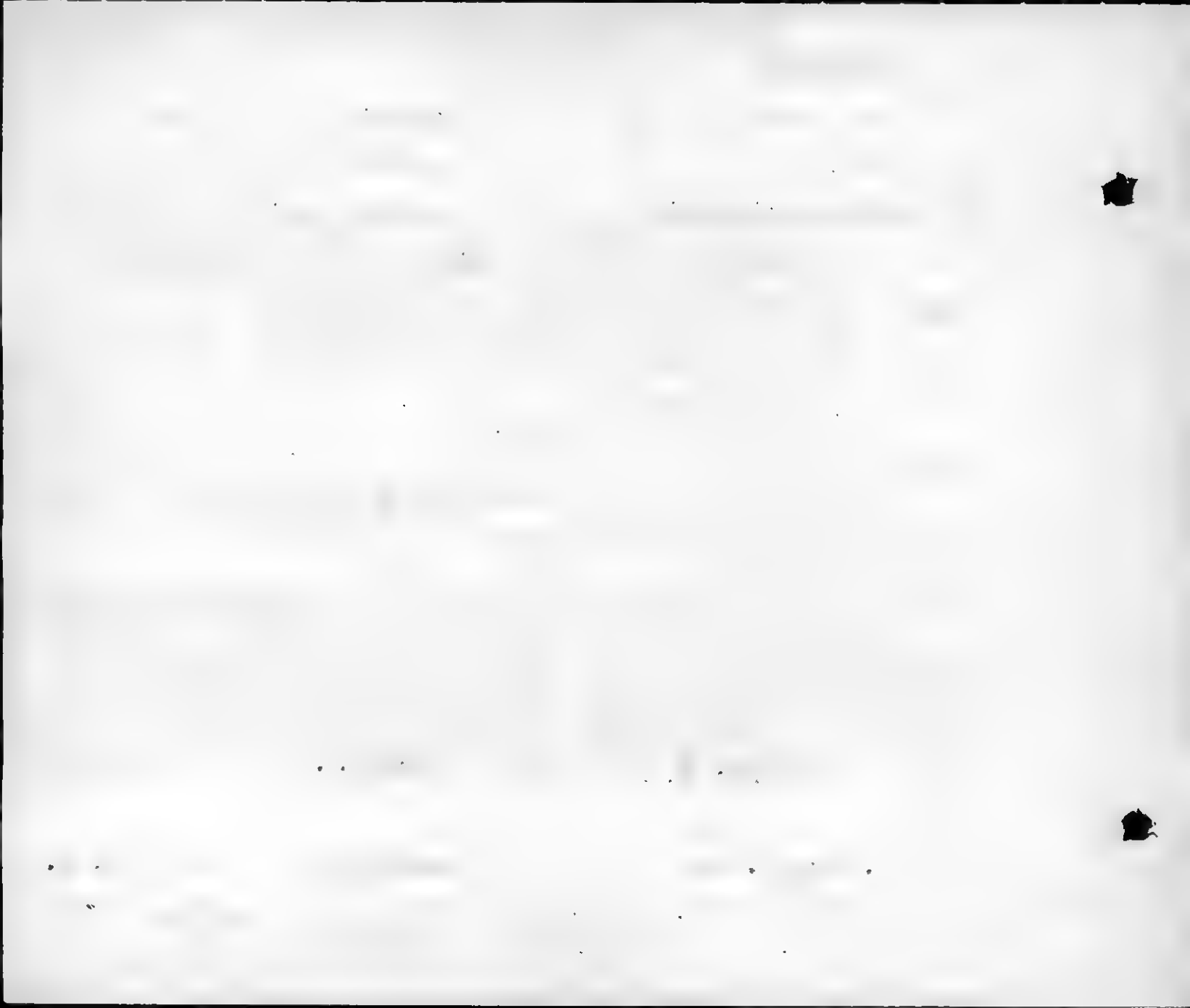
VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13400

13371

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 13 Tucker Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Hilda		First W. Middle White Last		4. DATE OF DEATH December 24, 1960		Month December Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug-26-1901	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.		IF UNDER 24 HRS Hours 59 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank J. Linhardt				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1-1-1-1-1-1-1-1-1-1		17. INFORMANT Arthur R. White		Address (2)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSION DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from DEC 20 11:10 A.M. to DEC 24 1960 , that (I) (was) last saw the deceased alive on December 24, 1960 , and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE Edward S. Beck				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Edward S. Beck				22d. ADDRESS Franklin Street Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 28-1960		23c. NAME OF CEMETERY OR CREMATORY Annapolis National		23d. LOCATION (City, town, or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Scully Sons				25a. REC'D BY REGISTRAR DEC 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	



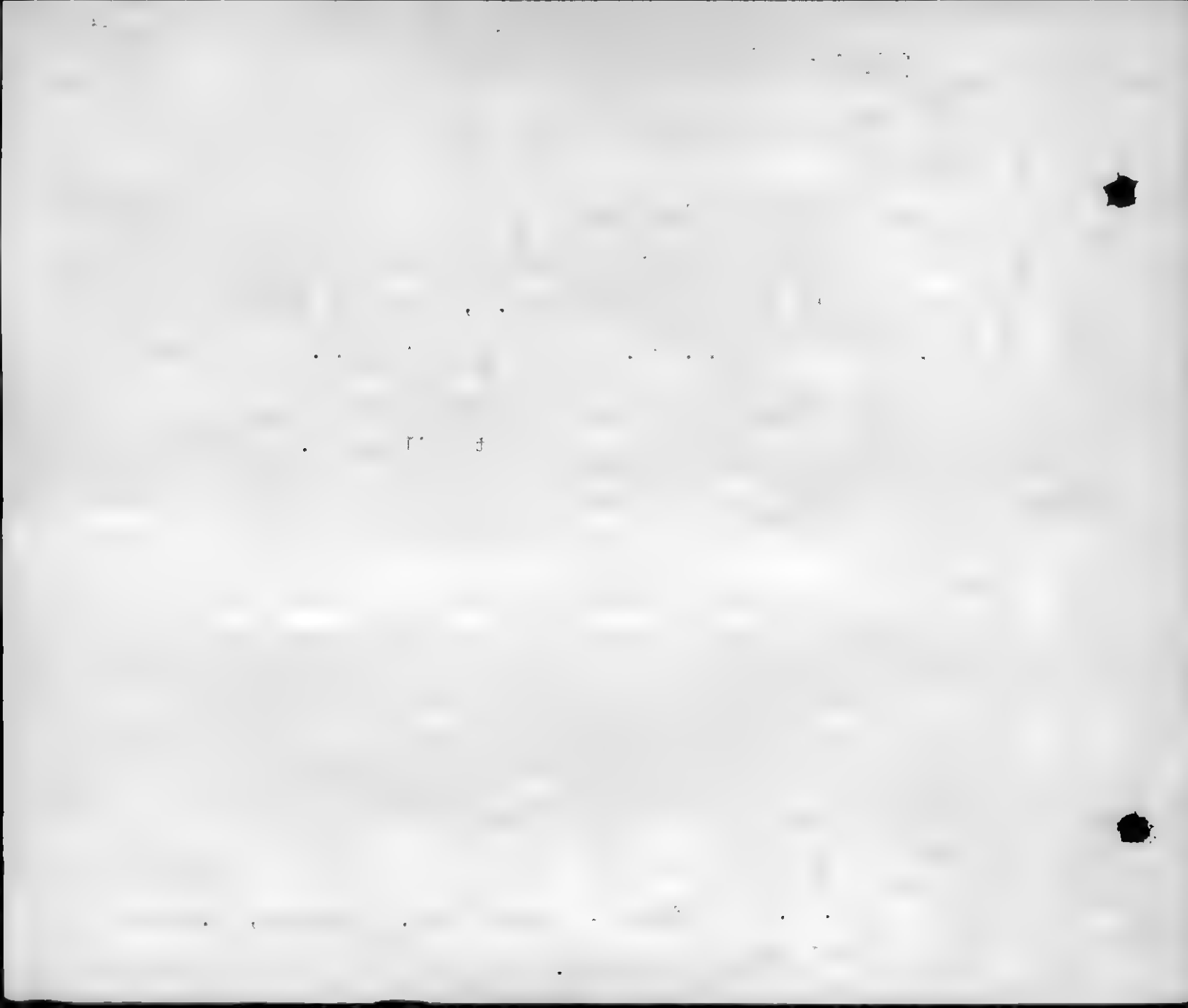
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13372 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13401														
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Anne Arundel General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo d. STREET ADDRESS Box 48 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Gladys Barrow WILLIAMS		4. DATE OF DEATH December 20 1960		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		9. AGE (In years (If UNDER 1 YEAR, last birthday) Months Days) 61 yrs.		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Alfred Barrow					14. MOTHER'S MAIDEN NAME Alma Harding									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO					16. SOCIAL SECURITY NO. NONE					17. INFORMANT Mr Robert I Williams Jr. Address same as # 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac 350x DUE TO Parkinson Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 121. 20. 60.														
ACTUAL SIGNATURE E. Linhardt		EXAMINER'S NAME (Type) E. Linhardt		DATE SIGNED 12. 20. 60.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1960		22c. NAME OF CEMETERY OR CREMATORY Arlington, National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Va.								
23. FUNERAL DIRECTOR Hopping Funeral Home		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DEC 27 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas								



TO HOSPITAL: The law requires that the death certificate be executed within 4 hours after death. The low requires that the death certificate be executed within 4 hours after death. The low requires that the death certificate be executed within 4 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13428

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13403

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3706 Clifton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle L. Last Williamson				4. DATE OF DEATH Month 12 Day 2 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April, 1935	
9. AGE (In years lost birthday) 25 yrs		10. IF UNDER 1 YEAR Months 25		11. IF UNDER 24 HRS Days 25		12. IF UNDER 24 HRS Hours 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Hezekiah Williamson				14. MOTHER'S MAIDEN NAME Eloise White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-30-3617		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchopneumonia							
300.7 DUE TO Schizophrenia							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)							
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Month, Day, Year Hour o. m. --- 19 p. m. ---				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----				20f. (City or town) (County) (State) -----			
21. I certify that (I) (this hospital) attended the deceased from 11/26 1960 to 12/2 1960 , that (I) (we) last saw the deceased alive on 12/2 1960 , and that death occurred at 2:40 P.M. from the causes and on the date stated above							
22a. SIGNATURE <i>[Signature]</i>				22b. DATE 12/3/60			
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION (City, town, or county) (State) A.A. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i>				25a. REC'D BY REGISTRAR DATE DEC 7 '60		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

[Handwritten signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13429

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13404

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel Co</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>AA Co</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>				c. LENGTH OF STAY IN 1b <i>5 1/2 yrs.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Knollwood manor</i>				d. STREET ADDRESS <i>1 unknown</i>			
3. NAME OF DECEASED (Type or print) First <i>James R.</i> Middle <i>Woodring</i> Last <i>Woodring</i>				4. DATE OF DEATH Month <i>12</i> Day <i>15</i> Year <i>1960</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4/22/1876</i>	
9. AGE (In years lost birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i> Hours <i>1</i> Min.		IF UNDER 24 HRS. Hours <i>1</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Waynesboro Penna</i>		11. BIRTHPLACE (State or foreign country) <i>Penna</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>Jacob Woodring</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Calmer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>				16. SOCIAL SECURITY NO. <i>None</i>			
17. INFORMANT <i>Mrs. Grace Norris</i>				Address <i>131 Hazel Ave. Balto. 27</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent Cerebral Thrombosis</i> DUE TO <i>Exacerbated Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Coronary Vascular Disease</i> DUE TO <i>Coronary Vascular Disease</i> (c) <i>Coronary Vascular Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>5 yrs</i> <i>5 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Myocardial Infarction</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <i>Waynesboro</i> (County) <i>Penna</i> (State) <i>Penna</i>							
21. I certify that (I) (this hospital) attended the deceased from <i>6/7/59</i> to <i>12/15/60</i> , that (I) (we) last saw the deceased alive on <i>11/29</i> 19 <i>60</i> , and that death occurred at <i>11:29</i> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Joseph Lipskey</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <i>JOSEPH LIPSKEY</i>				22d. ADDRESS <i>Odenton Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>				23b. DATE THEREOF <i>Dec. 15 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Burn Hill</i>	
23d. LOCATION (City, town, or county) <i>Waynesboro Penna</i> (State) <i>Penna</i>							
24. FUNERAL DIRECTOR'S SIGNATURE <i>Walter J. Groe</i>				ADDRESS <i>Waynesboro Penna</i>		25a. REC'D BY REGISTRAR <i>DEC 16 '60</i>	
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

13151

OFFICE OF THE

13151

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13373

CERTIFICATE OF DEATH

Reg. Dist. No.

13405

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS, MARYLAND	
c. LENGTH OF STAY IN 1b 1 DAY		d. STREET ADDRESS 56 MADISON PLACE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. NAVAL HOSPITAL, ANNAPOLIS, MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY BOY Middle "B" Last ZIMMERMAN		4. DATE OF DEATH Month DEC Day 31 Year 19 60	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-60
9. AGE (In years lost birthday) yrs. 10		IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME DAVID LEE ZIMMERMAN		14. MOTHER'S MAIDEN NAME SHIRLEY MAY TAYBURN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT U. S. NAVAL HOSPITAL		Address ANNAPOLIS, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY 771.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) HEMORRHAGIC DISEASE OF THE NEWBORN		INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-30 , 19 60 , to 12-31 , 19 60 , that I last saw the deceased alive on 12-31 , 19 60 , and that death occurred at 1050 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE J. M. Cann		M.D. U.S. NAVAL HOSPITAL, ANNA. MD. 1-1-61	
PHYSICIAN'S NAME (Type) LT JOHN J. MC CANN MC USNR			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-3-1961	
22c. NAME OF CEMETERY OR CREMATORY U.S. Naval Academy		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons		ADDRESS Annapolis, Md.	
24a. REC'D BY REGISTRAR DATE JAN 5 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

